

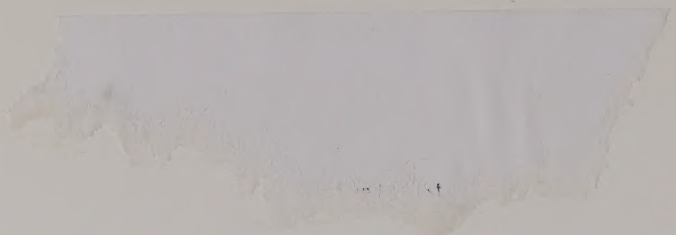


House of Commons

Committee of Public Accounts

NHS Local Improvement Finance Trusts

**Forty-seventh Report of
Session 2005–06**



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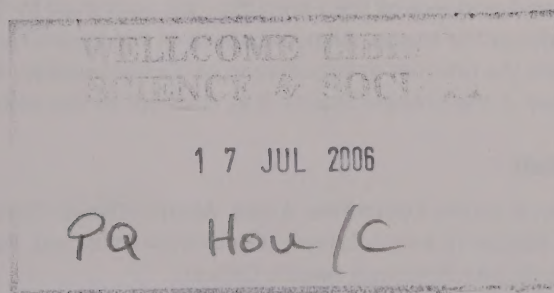
House of Commons
Committee of Public Accounts

**NHS Local
Improvement Finance
Trusts**

**Forty-seventh Report of
Session 2005–06**

*Report, together with formal minutes,
oral and written evidence*

*Ordered by The House of Commons
to be printed 12 June 2006*



The Committee of Public Accounts

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Mr Alistair Carmichael MP (*Liberal Democrat, Orkney and Shetland*)
Diana R Johnson MP (*Labour, Hull North*)
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Committee staff

The current staff of the Committee is Nick Wright (Clerk), Christine Randall (Committee Assistant), Emma Sawyer (Committee Assistant), Ronnie Jefferson (Secretary), and Luke Robinson (Media Officer).

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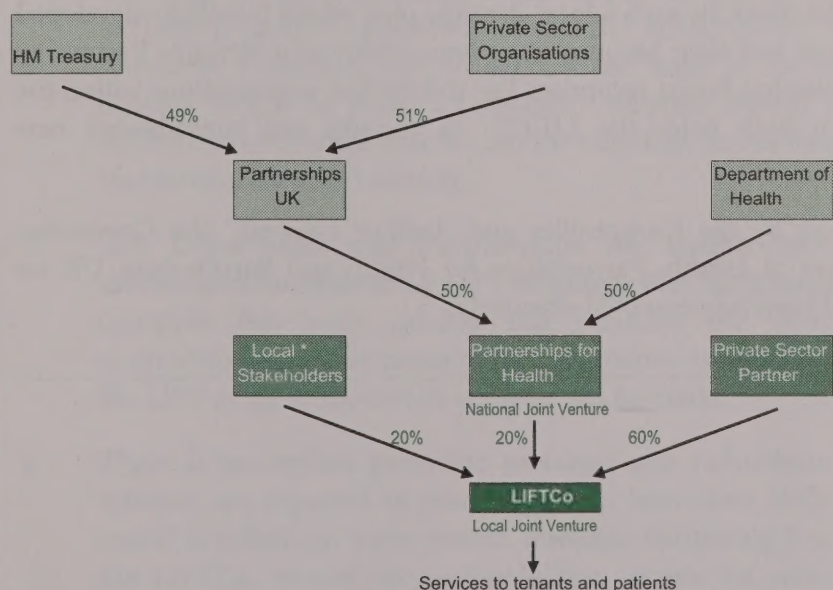
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Summary

The Department of Health launched Local Improvement Finance Trusts (LIFT) in 2000 to address long standing under-investment in primary care facilities. Primary care premises had historically been provided under a variety of arrangements – private ownership by GPs, private sector leases and central NHS provision. Less than half of the existing stock of primary care premises are purpose built. LIFT is a new form of Public-Private Partnership (PPP) that invests in new build primary care premises. LIFT aims to improve the overall quality of the primary care estate in England, and to create a more standardised market for private sector investment. In doing so it aims to improve and expand on the services available through co-location of services and offering services traditionally only available in hospitals.

A national joint venture, Partnerships for Health, was established between the Department of Health and Partnerships UK (itself a joint venture between the Treasury, Scottish ministers and the private sector) to oversee and invest in LIFT. Partnerships for Health takes a 20% shareholding in each local joint venture company (LIFTCo). A further 20% of the shares in the LIFTCo is owned by stakeholders in the local health economy and the remaining 60% by a private sector partner, selected through competition. The ownership structure is depicted in **Figure 1** below.

Figure 1: Structure of a LIFT Public Private Partnership



* Primary Care Trusts, Local Authorities, General Practitioners who wish to take a shareholding

Source: National Audit Office

LIFT aims to attract £1 billion of private investment into primary care by 2010. Start up funding of £195 million was made available by the Department. The total capital value of the first tranche of buildings in the first 42 schemes was £711 million, with an average LIFT building costing around £5 million. The first LIFT building opened in autumn 2004 and 51 local LIFTCos had been established across England by December 2005. These joint venture companies have exclusive rights to develop new primary care premises in their local areas over 25 years, using a standardised procurement process, subject to value for money tests.

Although the partners in the LIFTCo contribute equity, some 90% of the capital for developing LIFT properties is provided through debt. The properties are owned by the LIFTCo and income is earned through rental payments from tenants such as Primary Care Trusts, GPs, pharmacists and Local Authorities. Primary Care Trusts usually reimburse GPs' rents in full, but generally do not reimburse independent contractors such as pharmacists.

Tenants occupy space in LIFT buildings under Lease Plus Agreements (LPAs), which differ from conventional leases in important respects, making direct comparisons difficult. Rents under LPAs, for example, cover the whole lifecycle cost of the building as the landlord (the LIFTCo) is responsible for maintaining the premises to an operational standard throughout the asset's life. The risk profile differs in other ways too, for example, rent increases under LIFT are limited to the increase in the Retail Prices Index (RPI) unlike under a conventional lease.

Priorities for LIFT are identified through a local strategic plan which is initially developed by the Primary Care Trust, and then becomes the responsibility of a Strategic Partnering Board. The Strategic Partnering Board comprises key stakeholder organisations within the local health economy. It both holds the LIFTCo to account and commissions new developments.

On the basis of a Report by the Comptroller and Auditor General,¹ the Committee examined the Department of Health, Partnerships for Health and Partnerships UK on whether LIFT to date had been implemented effectively.

Conclusions and recommendations

1. **Primary Care Trusts have limited sources of public funds for developing new premises other than through LIFT.** Very few new primary care premises are funded through conventional public finance. The Department has, therefore, encouraged new premises to be developed through LIFT, in particular by providing funds to get the programme started. The main alternative is for Primary Care Trusts and GPs to commission a private contractor to develop premises which they can then lease, which is not always feasible in deprived areas.
2. **Providing new, purpose built primary care premises is more expensive than continuing with the existing estate.** The higher cost of LIFT mainly reflects the capital cost of new, high quality buildings compared to the cost of existing premises which are often much cheaper but not always suited to the delivery of modern primary care services.
3. **The higher cost of new provision, whether through LIFT or commissioning from contractors, could displace other primary care spending.** In preparing business cases for LIFT projects Primary Care Trusts should compare the cost of LIFT to the cost of the alternative procurement routes available, and make the implications for spending on other primary care facilities and services explicit.
4. **Primary Care Trusts in some areas subsidise other tenants to take space in buildings to encourage them to participate in LIFT.** Where Primary Care Trusts are paying sizeable subsidies to make LIFT affordable for other organisations, there should be a business case to support the value of the subsidy and the expected benefits should be made transparent. Subsidies should be used as a short term measure to encourage tenants into the buildings unless there are exceptional reasons that justify continued subsidy.
5. **The Department and Partnerships for Health have not yet developed a mechanism for evaluating LIFT although they have started to do so.** They should complete this work quickly and publicise the underlying mechanism and methodologies so that meaningful quantitative evaluation of the value for money of the LIFT programme and its schemes can be made.
6. **There is no explicit provision to target cost reductions over time.** Earlier LIFT schemes are expected to cost more than later ones, with costs reducing once the model is rolled out more widely. Strategic Partnering Boards, in consultation with the LIFTCo, should set cost reduction targets for new projects in the light of experience in the local LIFT area. There should be an annual review of progress against the targets, once buildings are operational.
7. **Under the Lease Plus Agreement, the LIFTCo is responsible for all repairs and maintenance.** There is no threshold level in the standard LIFT contract for minor alterations within a building. Some tenants within LIFT buildings are frustrated that they cannot procure minor alterations without prior consent from the LIFTCo and without going through a time consuming and bureaucratic process. Partnerships for Health should consult with the private sector partners and agree threshold levels of

expenditure below which any reasonable minor alterations could be carried out promptly and without recourse to the LIFTCo.

8. **New methods of care leading to centralisation of services can result in access problems for patients.** New arrangements sometimes lead to less convenient locations for patients, which can be a particular problem for those with mobility or transport problems. Primary Care Trusts should liaise with other relevant parties on location and access issues and give these priority in Strategic Service Development Plans and the business case for developments.
9. **The effectiveness of Strategic Partnering Boards is crucial to the performance of LIFT.** Chairs of Strategic Partnering Boards are appointed and remunerated by Primary Care Trusts. Members come from local stakeholder bodies. There is a risk that the Board can become a forum for discussion rather than a decisive and results focussed body. Partnerships for Health should help Primary Care Trusts and local authorities, where relevant, develop a framework for appraising the effectiveness of the Boards.

1 Affordability of LIFT

1. The LIFT initiative was introduced to remedy the poor quality of primary care premises in some areas. The alternative routes for procurement of new primary care developments are limited. Public funding is rare (with the exception of NHS Walk-In Centres) and tends to be on a small scale or targeted at basic refurbishment. Only 31 of 588 developments between 2000 and 2004 were classified as being publicly funded.² The main alternative for GPs (as self employed individuals) or Primary Care Trusts is to use a private contractor to develop new premises on their behalf. This route has not been used as extensively in deprived areas, leading to inequalities of provision across England. In areas where neither public funding nor third party development is available, LIFT schemes may be the only option for building new primary care premises.³

2. The Department's aim is for LIFT to improve the way in which the private sector provides primary care accommodation, in particular through ensuring that there is strategic input to the initiative not available through piecemeal development.⁴ Thus it supports LIFT in a way that it does not support other development routes. As well as assistance at national level for local developments through the activities of Partnerships for Health, enabling funds were made available to launch the initiative. The Department has the right to take back enabling funds but it has rarely been used. Enabling funds will not be available for subsequent tranches of developments.⁵

3. The rental charge for a LIFT building is usually higher than for other types of premises.⁶ GPs generally qualify for full reimbursement of their rent but other potential tenants within the LIFT building are more likely to be concerned about affordability. For example, pharmacists, dentists or Local Authorities will be expected to cover the additional costs of LIFT premises above those for their existing premises.⁷ It is difficult to make a direct comparison between the rent paid in a GP led development and that for a LIFT building because LIFT rentals cover a greater range of services, over the whole life of the building, and with a different mix of tenants. A reasonable comparison is between a large PCT led development in West Bromwich (one of the Sandwell PCTs), called the Lyng Centre for Health and Social Care, and the Oldbury Health Centre, one of Sandwell's LIFT developments. Even so the differences in the leases make interpretation of the figures difficult. The rental comparison is below.

2 Ev 18

3 C&AG's Report, paras 1.6–1.7

4 Q 12

5 Qq 41–52

6 C&AG's Report, para 2.14; Qq 3–4, 58–60, 82

7 C&AG's Report, para 2.21; Qq 89–90

Table 1: Cost comparison – LIFT versus Third Party Development

	Oldbury Health Centre (LIFT)	Lyng Health Centre (Third Party Development)
Capital construction cost (£ million)	4.1	12
Square Metres	2260	5760
Rental charge £/m ² of which:	229	195
Construction and finance	151	178
Facilities maintenance ¹	16	17
Lifecycle	21	n/a
Partnering/ LIFTCo management ²	33	n/a
Recovery of bid costs ³	8	n/a

¹ Maintenance in LIFT is inclusive of all maintenance across life of building, whereas under a standard internal repairing and insuring lease it only covers scheduled maintenance. The tenant usually pays for dilapidations at the end of the lease.

² Partnering and LIFTCo management costs relate to the setting up costs of the business whereas the Lyng development was undertaken by an established development business.

³ LIFT bid costs reflect that an exclusive contract for 25 years has been awarded to the LIFTCo. The rules on the number of schemes over which bid costs could be spread mean that there will be no bid costs from scheme 7 onwards. Lyng was a one off tender in the normal course of business for a developer.

4. LIFT rentals are based on the Lease Plus Agreement which includes payment for maintenance of the building. The LIFT rental charge is indexed annually in line with the Retail Prices Index (RPI), and cannot be increased any faster. In a conventional private sector development, increases in rental charges are unpredictable and are affected by the cost of maintenance and repair and market rental values. The tenant is usually also liable for necessary capital expenditure. The cost of LIFT also tends to reflect the greater quality and space within the accommodation than in existing GP premises and the greater scope of service provision.⁸

5. The LIFT rentals for GPs are generally reimbursed in full. To encourage other parties to take a tenancy some Primary Care Trusts choose to subsidise an element of their rent.⁹ The high cost of LIFT could lead to spending on other primary care premises and services being squeezed. On average less than 10% of patients within the Primary Care Trusts' boundaries were registered with GPs in the first tranche of LIFT buildings, although this percentage

⁸ Ev 20, 21–22

⁹ C&AG's Report, para 2.14; Qq 38–39, 53–57, 59

will increase over time.¹⁰ In Newham, in 2005/06, 9% of the PCT's patients were registered with GPs in LIFT accommodation. Nearly 30% of the total funding for primary care accommodation however, went to LIFT GPs (see Table 2 below).¹¹

Table 2: Analysis of GP premises costs in Newham 2005/06¹

	Patients registered with PCT	Percentage of total registered patients	Percentage of total primary care accommodation costs
Patients registered with GPs in Tranche 1 LIFT premises	27,927	9	28
Other patients	287,029	91	72
Total	314,956	100	100

1 Dr Kohli, a GP in a Newham LIFT development, provided the Committee with 2005/06 figures for Newham after discussion with the PCT. The PCT revised those figures in the light of more up-to-date information.

6. Primary Care Trust accommodation spending on patients registered with GPs in a LIFT development is up to eight times higher than total primary care spending on accommodation (see Table 3 below). The difference mainly reflects the cost of providing new, high quality and purpose built buildings.¹²

¹⁰ Qq 11, 93–97

¹¹ Q 11; Ev 21–22

¹² Ev 21–22

Table 3: Average annual primary care rent paid per patient versus average rent per LIFT GP patient

(A) LIFT area	(B) Actual PCT funding for primary care accommodation 2004–05 (£)	(C) ¹ Average annual cost per patient (£)	(D) ² PCT funding for GP premises in LIFT buildings in 2004– 05 on a annualised basis (£)	(E) ¹ Average annual cost per LIFT GP patient (£)
East London	10,708,000	14.22	422,760	28.73
East Lancashire	2,815,000	5.58	2,451,480	32.88
Ashton, Leigh & Wigan	2,081,000	6.90	967,238	29.23
Barnsley	934,000	3.92	635,376	16.48
Sandwell	1,229,000	3.84	635,400	31.41
Barking & Havering ³	3,432,000	8.20	0	0
2005/06 figures for Newham provided to PAC by Dr Kohli ⁴				
Newham PCT	3,223,099	10.20	899,180	32.20

1 Patient numbers are derived from Table 1 of the C & AG's memorandum, Ev 19.

2 Column D details the annualised PCT funding of GP accommodation for tranche one LIFT buildings for 2004–05. The LIFT funding has been annualised as, in some instances, the buildings only opened during 2004–05. LIFT funding is comprised of the annual rental charge payable by the PCT for premises and forms part of each PCT's overall primary care accommodation funding as detailed in Column B.

3 In 2004–05 the Barking & Havering LIFT building was fully occupied by PCT staff providing clinic services.

4 Dr Kohli, a GP in a Newham LIFT development, provided the Committee with 2005/06 figures for Newham after discussion with the PCT. The PCT revised those figures in the light of more up to date information.

7. LIFT buildings are designed to provide a range of health and social care services to other parties as well as to patients being treated by GPs. Patients within the Primary Care Trust's overall population who are not registered with a LIFT GP may still, therefore, be able to access specific services available in a LIFT building. Some of these may previously have been available only in a hospital, such as radiography or minor surgery.¹³

8. For the LIFT model to work efficiently there needs to be a continuous flow of developments. The LIFTCo is intended to operate as a local property development

business with overhead costs spread over a number of projects. Given the cost to the local health economy of developing LIFT buildings, and the long term funding requirements, there is a risk that a continuous flow of projects may not be taken forward. If so, the model may not achieve the expected benefits.¹⁴

9. There are processes in place to help achieve value for money, for example competitive procurement, review of business cases by Strategic Health Authorities and checks on the reasonableness of the rent by the Valuation Office Agency.¹⁵ There was competition from at least two credible short listed bidders in each LIFT area.¹⁶

10. The LIFT partnering agreement gives the LIFTCo an exclusive right to develop primary care premises for the Primary Care Trusts for five years providing it can demonstrate value for money by benchmarking. After five years the LIFTCo is required to market test the cost of undertaking new developments with outside suppliers (see paragraph 19). Granting the LIFTCo an effective monopoly for five years, provided the costs are reasonable, is intended to encourage private sector interest. Exclusivity does not have to apply to other premises, for example mental health or Local Authority developments. Where the LIFTCo fails to demonstrate value for money in terms of operating costs, through benchmarking or market testing, Primary Care Trusts are free to use any supplier they choose.¹⁷

11. Some healthcare professionals working within the LIFT buildings report that the terms of the LIFT contract can make it difficult and expensive to carry out or procure minor alterations. The lease agreement states that tenants can only do so with the prior consent of the LIFTCo, but the time delay and bureaucracy involved in getting LIFTCo approval often causes frustration. In practice this provision is being taken by some LIFTCos to cover not only minor structural alterations, but for example something as straightforward as GPs wishing to erect a new notice board within the surgery. Minor variation is not defined or quantified in the standard Lease Plus Agreement.¹⁸

12. As debt is cheaper than equity the public sector sought to keep equity to 10% of the financing of LIFT developments. The equity rates of return to the LIFTCos for initial developments across the first 42 schemes ranged between 12.64% and 16.54%, with an average of 14.75%, which is slightly higher than the going rate for equity returns under the Private Finance Initiative of between 12.5% to 15%.¹⁹ There are concerns that the returns in LIFT are high in relation to the level of risk taken by the private sector. Returns for the early schemes may have been higher because of perceived greater risk associated with the newness of the schemes, and uncertainty over the pace of future developments. Partnerships UK consider there may be some scope for them to reduce as subsequent tranches of schemes are rolled out and confidence in the LIFT model increases.²⁰ As LIFTCo is a public private partnership, the public sector's share of returns, i.e. the 20% due

14 Qq 43, 82

15 Q 7

16 C&AG's Report, para 2.8; Q 7

17 Qq 16–18; C&AG's Report, para 2.33

18 Q 11

19 C&AG's Report, para 2.21, 2.30; Q 2

20 Q 2

to the Primary Care Trust, will be reinvested in the local health economy. GPs, as self-employed individuals, would not be obliged to reinvest any returns made in developments they undertook.²¹

21 C&AG's Report, para 2.30; Qq 2, 80

2 Realising the expected benefits of LIFT

13. It will be many years before the expected benefits of delivering services to local communities through LIFT can be realised. Some important groups of stakeholders, notably GPs, pharmacists, dentists and Local Authorities, are not all supportive of the LIFT model.²² For example, in the East Lancashire scheme local independent pharmacies have said they were discouraged from competing for a tenancy in the LIFT buildings because they perceived that contracts were likely to be awarded to national players who were not interested in forming a consortium with them. In the Church Road development in East London, however, local independent pharmacists have formed a consortium enabling them to provide services from the LIFT building.²³

14. One intended benefit of LIFT is the co-location of a range of healthcare services. Secondary care can be made available in a primary care setting, allowing faster and more convenient referrals, where the relevant specialists hold clinics in LIFT premises. There is concern, however, that such benefits may not be fully realised in the absence of integrated IT systems allowing quick referrals and data transfers between GPs and the hospital patient administration systems, which control access to specialists. Where there is no such integration, the GP may still have to write formally to the hospital to arrange a referral for their patient, even when the specialist works in the same LIFT building.²⁴

15. The quality of local implementation of LIFT will have a big impact on its success. As a central oversight organisation, Partnerships for Health can play an important role in helping local LIFT areas realise their longer term strategies. Partnerships for Health helped local areas establish their LIFTCos through the provision and dissemination of guidance, stimulating interest in LIFT through forums and conferences and by providing a facilitator to assist each scheme.²⁵ Now that LIFTCos are operational, Partnerships for Health have a director on each LIFTCo Board reflecting their 20% shareholding in each local scheme. Partnerships for Health are, therefore, well placed to ensure that knowledge is shared and disseminated and that lessons for the future continue to be learnt.²⁶

16. New patterns of care can affect the location of developments and, therefore, have an adverse impact on access to services for some patients. For example, GPs currently serving deprived areas of cities and towns may be encouraged to relocate more centrally within the new LIFT buildings, with the result that patients have to travel further. The location of health services is the responsibility of the Primary Care Trusts and should be based on meeting the priorities outlined in their Strategic Service Development Plans. Provision for the patients within a LIFT area who are likely to find it difficult to reach a LIFT building, such as the elderly and people dependent on public transport, needs to be considered

22 C&AG's Report, para 2.14; Qq 10, 21–26, 30–37

23 Qq 23–26

24 Qq 83–88

25 C&AG's Report, paras 1.13–1.14

26 *ibid*, paras 1.26, 3.11

within this wider aim. This early involvement of the local authority, particularly in relation to public transport, is likely to have a beneficial impact.²⁷

17. The creation of well designed and fully functional buildings, suitable for delivering the primary and social care needs of the local population over the next 20 years, is an important factor in ensuring LIFT can realise its full potential. Partnerships for Health has collaborated with the Commission for Architecture and the Built Environment (CABE) since LIFT's inception and are now, together with CABE and the Department's Estates team, undertaking full design reviews of all buildings provided to date with the intention of learning design lessons for the architects on future schemes. This collaboration should avoid last minute concerns about the design of LIFT buildings and modifications being made at a late stage as has been the case, for example at the St Peter's health and leisure development in Burnley.²⁸

18. Formal guidance on accountability and governance frameworks was only developed after the initial LIFT schemes became operational. The Strategic Partnering Board holds the LIFTCo to account, and is responsible for commissioning new LIFT developments and services. Primary Care Trusts appoint the Chair of the Strategic Partnering Board. Members are from key stakeholder organisations within the local health economy such as Strategic Health Authorities, Local Authorities, Primary Care Trusts, and healthcare professionals. They are accountable to their own organisations. No central body holds the Strategic Partnering Board to account. By its nature there is a risk that the Strategic Partnering Board may become a forum for debate rather than the decisive, results oriented body needed to make LIFT effective.

27 Qq 27–29

28 C&AG's Report, Appendix 3; Q 20

3 Evaluating the impact of LIFT

19. The first LIFT building to become operational, the Church Road centre in Newham, opened in Autumn 2004. It will be several years before the full impact of the LIFT initiative, particularly in terms of health outcomes, can be evaluated fully. Nevertheless, the arrangements in place for evaluation and performance measurement need to be robust to ensure that the impact of LIFT, and whether it is meeting its objectives, can be assessed.²⁹

20. The Strategic Partnering Agreement, to which all partners in a LIFT scheme sign-up, requires the LIFTCo to demonstrate that it is delivering value for money in relation to new projects by market testing or benchmarking. Market testing is undertaken at minimum at five year intervals. In the first five years the LIFTCo is allowed to demonstrate value for money through the production of benchmarking data. Any relevant data, such as the costs agreed as a result of the original competition or trends in the area, nationally and on other LIFT projects, can be taken into account.³⁰

21. Comparing the value for money of LIFT with other procurement routes is not straightforward because the LIFT framework is designed to offer tenants more and better services than obtainable under a standard commercial lease. LIFT also delivers a broader and more complex range of services to patients than typical primary care premises. Moreover, the contribution of the LIFT initiative to better health outcomes or to the wider community, for example in terms of meeting a local regeneration agenda, is hard to quantify.³¹

22. The Department and Partnerships for Health have not yet developed a mechanism for evaluating the impact of LIFT in terms of its broader aims or in comparison to other primary care procurement routes.³² Partnerships for Health have therefore commissioned further work to evaluate the long term impact and value for money of LIFT. They are currently scoping the likely format of an evaluative tool, with input from local LIFTCos.³³ The aim is to assess the cost of providing facilities, the benefits to patients and the impact on longer term health outcomes.³⁴

23. The measurement of health outcomes, however, is the least straightforward aspect of a benchmarking tool to define. Proxy measures related to key local health problems identified in the Strategic Service Development Plan could, however, be developed. For example, if a plan identified a high level of lung cancer or obesity as key local issues then a priority for LIFT would be to contribute to reducing the proportion of the population who are smoke or are obese over the longer term. In the short term, however, an indicative

29 C&AG's Report, para 13, recommendation 9; Q 7

30 C&AG's Report, para 2.33

31 *ibid*, para 2.20; Qq 89–91

32 C&AG's Report, para 1.27; Q 12

33 C&AG's Report, para 2.33; Qq 18–19

34 Q 90

measure could be the number of additional smoking cessation_clinics or healthy eating classes taking place as a result of LIFT.³⁵

35 C&AG's Report, para 3.10

Formal minutes

Monday 12 June 2006

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon
Annette Brooke
Greg Clark
Helen Goodman

Mr Sadiq Khan
Mr Austin Mitchell
Kitty Ussher
Mr Alan Williams

A draft Report (NHS Local Improvement Finance Trusts), proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 23 read and agreed to.

Summary read and agreed to.

Conclusions and recommendations read and agreed to.

Resolved, That the Report be the Forty-seventh Report of the Committee to the House.

Ordered, That the Chairman make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned until Wednesday 14 June at 3.30 pm.]

Witnesses

Monday 17 October 2005

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Mr Peter Coates CBE, Department of Health, **Mr Brian Johns**, Partnerships for Health, **Mr James Stewart**, Partnerships UK, and **Dr Bhupinder Kohli**

Ev 1

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Twentieth Report	The NHS Cancer Plan: a progress report	HC 791 (<i>Cm 6766</i>)
Twenty-first Report	Skills for Life: Improving adult literacy and numeracy	HC 792 (<i>Cm 6766</i>)
Twenty-second Report	Maintaining and improving Britain's railway stations	HC 535 (<i>Cm 6775</i>)
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Twenty-fourth Report	The BBC's White City 2 development	HC 652
Twenty-fifth Report	Securing strategic leadership in the learning and skills sector	HC 602 (<i>Cm 6775</i>)
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Twenty-seventh Report	Lost in translation? Responding to the challenges of European law	HC 590 (<i>Cm 6775</i>)
Twenty-eighth Report	Extending access to learning through technology: Ufi and the learndirect service	HC 706 (<i>Cm 6775</i>)
Twenty-ninth Report	Excess Votes 2004–05	HC 916 (<i>N/A</i>)

Thirtieth Report	Excess Votes (Northern Ireland) 2004–05	HC 917 (<i>N/A</i>)
Thirty-first Report	Northern Ireland's Waste Management Strategy	HC 741
Thirty-second Report	Working with the voluntary sector	HC 717 (<i>Cm 6789</i>)
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Second Special Report	The BBC's White City 2 development: The response of the BBC Governors to the Committee's Twenty-fourth Report of Session 2005–06	HC 1139 (<i>N/A</i>)
Forty-seventh Report	NHS Local Improvement Finance Trusts	HC 562

The reference number of the Treasury Minute to each Report is printed in brackets after the HC printing number

Oral evidence

Taken before the Committee of Public Accounts

on Monday 17 October 2005

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon
Greg Clark
Ms Diana R Johnson

Jon Trickett
Kitty Ussher

Sir John Bourn KCB, Comptroller and Auditor General and Ms Patricia Leahy, Director of Public-Private Partnerships Studies, National Audit Office, were in attendance and gave oral evidence.

Mr Brian Glicksman CB, Treasury Officer of Accounts, HM Treasury, was in attendance.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

INNOVATION IN THE NHS: LOCAL IMPROVEMENT FINANCE TRUSTS (HC 28)

Witnesses: Mr Peter Coates CBE, Deputy Director of Finance and Investment, Department of Health, Mr Brian Johns, Chief Executive, Partnerships for Health (PFH), Mr James Stewart, Chief Executive, Partnerships UK and Dr Bhupinder Kohli, examined.

Q1 Chairman: Good afternoon, welcome to the Committee of Public Accounts. I should start by welcoming Mr Oxikbayev, who is Chairman of the Chamber of Accounts of Kazakhstan, and his colleagues. You are very welcome. Today we are considering the Comptroller and Auditor General's Report Innovation in the NHS: Local Improvement Finance Trusts, which examines a new public-private partnership model for providing primary care facilities which is called LIFT. We welcome the witnesses: Brian Johns, who is Chief Executive of Partnerships for Health; James Stewart, who is Chief Executive of Partnerships UK and Peter Coates, who is Deputy Director of Finance—Investment, in the Department of Health. A general question to start with. What do you think will be the main benefit for patients from LIFT?

Mr Coates: It is certainly a revolutionary way to deliver health care for the NHS and it has brought in an unprecedented investment in primary care facilities to the NHS. To date we have started work on buildings worth £866 million and of that £671 million is through building works and £195 million through enabling money provided by the Department of Health. By the end of the year we think it will be £71 million in further new starts, making a grand total this year alone of £937 million. We think it has improved access to health care in areas of most need, closer to home, with a wider range of services under one roof. The best example of variety under one roof which I can give is in Newcastle which is a place opened this month where there are over 100 services under one roof.

There are the usual NHS one-stop shop services; there are also council house services, a community police station, a job centre and a library. At Colchester and Tendring there will be a renal dialysis unit meaning patients no longer have to travel to London, Ipswich or Cambridge.

Q2 Chairman: Could you look at figure 11, which you can find on page 27 of the Comptroller and Auditor General's Report? LIFT projects are described as attractive to the private sector because they are "low risk", but at 15% are the rewards not quite high? Why are they so high?

Mr Coates: I should like to bring James Stewart in later on, if I may, to discuss what the expected rate of returns are to be, but LIFTs are not particularly low risk for the private sector. For example, if the building is not delivered on time and to budget they bear that risk. In terms of the IR rate of return they make, we obviously benchmark these against rates similar in other contracts within government and we believe that 15% is about the going rate for risk equity in the private sector. Perhaps I might ask James to come in and talk a bit more about equity rates.

Mr Stewart: If you compare equity rates with the PFI market, they are comparable, possibly just a little bit higher. There are two reasons for that. One is that the equity rates you are looking at here are effectively for the first six deals and indeed the rate at which we rolled it out would probably cover the first 20 or so deals. In time future tranches will flow through LIFT and we may well see equity returns come down.

Q3 Chairman: Some criticise this because the private sector is charging quite a lot for occupancy. Do you think that is a fair criticism?

Mr Coates: What do you mean?

Q4 Chairman: For the occupancy. Because their costs are high they are having to charge more. We will bring in a GP in a moment, but some GPs are saying that this is quite an expensive scheme and therefore it may be taking resources from other parts of the NHS. Is that a fair criticism?

Mr Coates: You have to look at what you get for your money and you have to make sure you compare apples and apples and pears and pears in terms of value for money. No doubt we will have a discussion later about what value for money is and how it is measured. I note the Report does say it is quite difficult to compare traditional third party developer developments and LIFT, but we believe that if you take the full life costs of both options and price in the risks we retain in the public sector for third party developers and price in the benefits received from LIFT, the cost per square metre of development is better for LIFT than it is for third party developers.

Q5 Chairman: Can we look at the evaluation now? If you look at page 16, paragraph 1.24, could you tell the Committee why you proceeded with waves 2 and 3 without a complete evaluation of the pathfinder and wave 1 schemes? It seems that there is only a gap of about a year between the pathfinder schemes and actual implementation. Do you think this was a good idea? Should there not have been more evaluation at the time?

Mr Coates: Obviously with the NHS it is a large and rapidly changing market, even more so when government funding is increasing so rapidly. In these situations with large programmes like LIFT you have to be able to be flexible to changing priorities. Officials were asked, the question was put to officials, whether they thought it was a good thing to telescope the programme down to meet our changing priorities and we considered that it was a risk we could manage and take. We did put extra resources into the support programme through the Department of Health and through Partnerships for Health. In hindsight we can look back and say perhaps it worked fairly well. If you look at the number of different services which have come out of LIFT, for example, it would be quite difficult with a single pilot to imagine how many different kinds of service there would be. If we said we would have two or three pilots, we could actually stifle innovation, stifle growth. We do not think it caused any slippage to the overall programme and by and large, with hindsight, we think it was a decision well made.

Q6 Chairman: Could I ask you about co-location now, which is dealt with in paragraph 1.4 on page 10? Could you explain to the Committee the extent to which LIFT has been successful in achieving the desired co-location of primary care professionals and associated services?

Mr Coates: It is policy that we try to bring care closer to home in the NHS. One of the best examples we saw was last Thursday when we went round to the Church Road development and saw there an example where four acute consultants are now stationed regularly in the one-stop shop and able to treat patients locally. I believe that it was said there that doctors were able to refer patients across the room on a contemporary basis as they came in through the door for treatment.

Q7 Chairman: May I just return to evaluation? If you look at recommendation 9, which you can find on page 7, it says "The Department should establish a framework with which it can establish and evaluate the impact of LIFT". Can anyone know whether LIFT is really working in the absence of any proper national evaluation?

Mr Coates: I agree with your sentiment in the sense that this is very much work in progress and we will not know for some time whether value for money and success have been achieved. I would point out that the indicators so far have all been very positive. The Report itself recognises that LIFT is an effective solution, offers value for money and I should be quite happy to run through on a stage by stage basis the indicators we have as time goes on in terms of evaluating value for money and success. For example, the initial competition to select a partner for each LIFT was described in the Report as being robust and successful and overall value for money was judged to be the main criteria for selecting partners. So each trust's partner was selected on the basis of a fair and robust competition. In relation to schemes as they come forward, we have a whole range of measures which we can apply to ensure value for money is secured. We have the business case review system, which ensures all business cases go to the Strategic Health Authority (SHA) if they are above a certain value. The District Valuer, part of the Valuation Office Agency, tests rents to ensure that they are fair. We have professional testing of estimates from the advisers the Primary Care Trust (PCT) employ and, a very important step in terms of the future, some benchmarking work which we are starting with PFH on which I can go into more detail for you now or later if you wish.

Q8 Chairman: May I ask you about the strategic partnering board (SPB) which is mentioned in paragraph 3.15 on page 32. It says there "The accountability of the LIFTCo to the strategic partnering board is well defined. It is unclear, however, to whom the strategic partnering board is responsible. Who holds the strategic partnering board to account? Who makes sure that it is effective?"

Mr Coates: The SPB is a cross-organisation body which is designed to sit and discuss the needs of the local economy. We expect and know that the representatives on that panel are the senior members of the various bodies and given that they are all accountable back to their home organisation it is hard to see how one body could hold these

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people to account, bearing in mind that they are not all NHS employees. It seems to me to be one of these issues of where the buck stops. These are all people who are very senior and they are all accountable back to their boards and putting another layer of control on top of them seems to be—

Q9 Chairman: That is a fair answer, but would it not also be a fair criticism that this is one of those typical schemes which we have increasingly in the public sector where many people seem to have a hand but no hand is dominant, therefore there may be a lack of accountability?

Mr Coates: I accept that there is that risk and the question then is how you track through projects or different schemes to ensure that they are delivered. The process of events is simply that a sponsoring department, be it a local authority or whatever, will take a scheme to the SPB and seek approval for it and agreement that it fits into the necessary plans. Ultimately that scheme is tracked through their own boards and their own accounting structures through to their own responsible officers. Nothing will go into the system unless it is chased through by a sponsoring body.

Q10 Chairman: The LIFT schemes appear to have encountered some resistance from GPs. Why? What are you doing to gain their support?

Mr Coates: I am sure that some GPs will resist change because change itself is a threat and different. There may also be an element of GPs believing that it is more expensive or whatever and there may be an issue around rent reimbursement. All we can do is provide the necessary framework to allow the PCTs to negotiate with the GPs and reach agreement about transferring into the centres if they can.

Q11 Chairman: As it happens, Mr Bacon and I, on behalf of the Committee, visited one of these schemes in Newham last week and it was very interesting. There is no doubt that the facility we visited was a superb facility, but we did encounter there some people on the ground and I should like to call forward now Dr Kohli, if I may, who works at the Newham centre. He seemed to intimate to Mr Bacon and me that whilst it was a superb facility and very popular with doctors, he had some worries about how much money was being drained off other services in Newham. This is your chance, Dr Kohli, just to give the same answer to this Committee now that we are meeting formally in the House of Commons that you gave to us informally in Newham last week and give us your impressions of what financial consequences there might be of this scheme in Newham.

Dr Kohli: I prepared a short document which I circulated to you earlier today.¹ The buildings are fabulous, there is no doubt about it, but the cost is of concern. For instance, just to give you a figure, the cost of the two new LIFT buildings which have

been completed in Newham now, which cover 8% of the population, the total spend from our total premises expenditure budgets for all GP surgeries for 310,000 patients who are registered, is 33% of the budget spent on 8% of the buildings. I personally have no objection to spending money because I like the idea of working in a great new building. My concern is for the practices which do not have that opportunity because at the end of the day the NHS does have a limited pot to work with. To illustrate it further, we have done a pounds-per-patient calculation. The average pounds-per-patient spend on non-LIFT buildings, on premises costs, divided by the list size, patients registered in that practice, is £8 per patient. For the two LIFT buildings which have been completed it has come out at £43.40 per patient. In my world and having had a little bit of experience of managing NHS budgets, having been involved in commissioning and chairing a PCT executive committee not too long ago, these are significant cost burdens to take on board. I am not opposed to these buildings: I am just concerned about the cost. The other concerns I have around it are any variations. Traditionally in general practice when you want to make alterations or make improvements, which are inevitable, no building can be built perfectly for the next 20 years, you are able to go to an open market, get three quotes and the PCT finance department will approve the cheapest quote as long as it meets their quality standard. In LIFT you are living with a landlord who has a monopoly provider status for all alterations, be they small or large. There is no competition, it is a monopoly and it is for 20 years. So my concern around that is that we may stop doing the small alterations because we are worried about the cost which will have an effect and consequence on patients and patient services. Those are the two concerns I have.

Chairman: Thank you for that view from the grassroots. It is always quite important for this Committee occasionally to get those views. Thank you very much.

Q12 Kitty Ussher: I have a couple of broad questions and then some which I have drawn from the experience of a LIFT building which is going up in my part of the world which is Burnley in Lancashire. It looks splendid at the moment. First the general ones. Could you just explain from first principles why doing projects in this way is preferable to direct funding from national government?

Mr Coates: The first thing to say is that what we are doing is trying to improve a market which is there already. We are not saying this is instead of public funding: public funding is still there. What we are trying to do in LIFT is improve the way that the private sector currently allocates and provides primary care property. We are not trying to take out public sector money, we are not trying to replace GP-owned developments, we are looking at a particular sector, which is third-party developers, which we believe could offer better value to the taxpayer if done differently.

¹ Ev 17–18

Q13 Kitty Ussher: You said that has not been proven in terms of value for the taxpayer. Is that right?

Mr Coates: What I said was that in all these long-term investments you will not have proof positive that it is value until you have gone some way down the path. If we look at the indicators we have so far, these indicate that what we are doing is value for money.

Q14 Kitty Ussher: When will that finally be proven or not?

Mr Coates: We have some work in hand around benchmarking and long term learning which is an essential and integral part of LIFT and an integral part of the recommendations in the Report, which we accept.

Q15 Kitty Ussher: So you believe that in the medium term it will be value for money for the taxpayer.

Mr Coates: I personally believe that in the short term and the long term it will be value for money.

Q16 Kitty Ussher: I understand that the LIFTCo effectively has a monopoly on the provision for five years. Is that right? Then the PCT can market test it.

Mr Coates: It is not quite as simple as that. How it works in terms of services is that the contract allows for partnering agreements to be set up which are long-term agreements whereby you have an agreed list of suppliers providing services to the LIFTCo. What is a monopoly is the agreement that all primary care contracts which the PCT wants to let which are partnering in nature go through the LIFTCo. If the PCT, for example, wants to develop mental health facilities or acute facilities, then there is no obligation to use LIFT. Indeed if the LIFTCo cannot demonstrate value for money to the PCT then the PCT is free to go elsewhere.

Q17 Kitty Ussher: Do you accept that there is a monopoly for certain types of services?

Mr Coates: The partnering services certainly. If you want to partner a contract through that company which is using the supply chain provided by the LIFTCo, then there is a monopoly.

Q18 Kitty Ussher: How long does that last for?

Mr Coates: Five years?

Mr Johns: The overall partnering arrangement lasts for 20 years, that is the partnering agreement. The LIFTCo, which is not just the private sector of course it also includes the public sector, it is a public-private partnership, has the right, indeed obligation, to respond to PCT requests for new capital schemes during that period. I think perhaps what you may be referring to is that in the first five years the LIFTCo is able to demonstrate value for money by using benchmarking of costs of schemes without having to go to market testing, out to competitive tender, but after five years it cannot use the same supply chain using benchmarking to demonstrate value for money, it is obliged to go out

to competitive tender. To reiterate what Mr Coates said, any scheme which is developed by the LIFTCo has to demonstrate value for money and if it fails to do so, the Primary Care Trusts or local authorities are free to use any other supplier it chooses.

Q19 Kitty Ussher: Thank you for that clarification. The point I am probing is if it is the snazziest outfit in town, which it often appears to be, how can you do a proper competitive market appraisal, whether it is benchmarking or market testing? Has there been an analysis of that?

Mr Johns: In terms of the market testing the important thing is that the LIFTCo is made up essentially of three partners: one private sector partner and two public sector partners. It is that public-private partnership company which has the exclusivity. Beneath that public-private partnership is a raft of supply chain members, whether design, architects, construction contractors, maintenance providers and so on and the LIFTCo can choose from the raft of providers to provide the particular service on a particular building. It may choose one contractor for a very large building and a different local contractor for a small building. The exclusivity does not mean the individual contractors are set in stone for the next five years.

Q20 Kitty Ussher: That is extremely useful; thank you. Might I turn to issues which have arisen locally? I have to say, so that people can understand, that we have a building powering up in the centre of my constituency which is a health and leisure centre and people are amazed by how good it looks as though it is going to be. However, some specific issues have arisen. I have four specific ones. The first one is on design and architectural design where about two weeks before the contractor was due to start digging the hole huge concerns were raised by CABE, the Commission for Architecture and the Built Environment, which is the national body to look at architectural standards. I felt that there were some last minute modifications made to the design as a result of that, but I suspect that had those come sooner there would have been more substantial revisions, to be honest. How can we make sure this situation is avoided in future?

Mr Johns: Partnerships for Health have collaborated with CABE since the very start of LIFT and indeed we invited them to comment and they did comment on the original technical specification for LIFT. They also provided design enablers on a number of the schemes which were the original schemes to be developed. They are working with us on the fourth wave of LIFT, again providing design enablers, but they have limited resources, so they are not able to provide an enabler for every scheme. The most important answer to your question is that we are now working with CABE and DoH Estates to undertake a design review of all the LIFT buildings which have been developed to date. The intention of that design

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review is actually to provide lessons for designs for architects for future schemes. That is how we are systemically addressing the design issue.

Q21 Kitty Ussher: Thank you very much; that is encouraging. We obviously have a huge shortage of dentists in my part of the world—I am sure I am not alone—and my constituents are desperate to see as many dental seats in there as possible available to the public on the NHS. Are there any guidelines as far as you are concerned to ensure that happens?

Mr Coates: I am not aware of any formal guidelines on the number of dental facilities to provide within LIFT. If you wanted a note, I would have to come back to you with that. I am sorry.²

Q22 Kitty Ussher: It would be useful to know whether there are.

Mr Johns: There are actually dentists taking up occupation in buildings already. We have about a dozen dentists and in fact in Birmingham we have a dentistry training facility which has been developed as part of the initial LIFT scheme there.

Q23 Kitty Ussher: It is obviously a great opportunity. There has been concern amongst local independent pharmacies that the way that the contracts are being given for pharmaceutical services inside the new LIFT building effectively crowds out local provision. My understanding of current government policy is that they do wish to support independent pharmacies. That certainly will not happen as a result of the way the contract has been let in my constituency, which is a pity. They have not felt able to bid commercially. Is that something you are seeking to avoid?

Mr Coates: No. There is no guidance of which I am aware where we say that sectors cannot bid for franchises in LIFTCos and there is certainly no central guidance which tries either to target or limit independent involvement in LIFT premises.

Mr Johns: Indeed on the visit last Thursday there were two representatives from local pharmacies who were there, who are operating from the facility we visited in Church Road in East London. What they told us was that the local independent pharmacists had formed a consortium so that they could provide services from the LIFT building. I think that is a model which has been considered in other localities as well.

Q24 Kitty Ussher: Perhaps I could pose the question the other way. We only have one or two local independent pharmacies which are interested and I think that the national players are not interested in forming a consortium with them, so they are completely unable to compete in the absence of guidelines to say that local pharmacies should be looked at sympathetically. Should we not have that?

Mr Coates: Is your question around the money side of it, affordability?

Q25 Kitty Ussher: I presume it is money. I presume that the large pharmacies like Boots and Moss—I do not know the specifics—are able to undercut by virtue of economy of scale.

Mr Coates: My understanding on the pharmacy side in LIFTs is that PCTs can support the rental cost within the development. For example, if they feel that it is essential that there is a pharmacy within the building then they can subsidise the rental paid by the independent contractors.

Q26 Kitty Ussher: So this is something we can take up with the PCTs.

Mr Coates: Yes.

Q27 Kitty Ussher: There is also concern that some GPs who are currently based in deprived areas, which is seen as a good thing, will be sucked into this momentum to relocate into the centre of town. Is that something you are seeking to avoid?

Mr Coates: To avoid?

Q28 Kitty Ussher: Yes.

Mr Coates: The location of health services within any economy is clearly down to the local PCTs and their Strategic Service Development Plan (SSDP). All LIFT tries to do is to provide a framework within which we can provide assets and services flexibly to the local economy. There is no central guidance of which I am aware which tries to do what you are suggesting in terms of bringing people in from the suburbs.

Q29 Kitty Ussher: Do you accept that if the facilities offered in a LIFT centre are of excellent quality then GPs may be more likely to want to move there and thereby provide a less good service to people out in deprived communities?

Mr Coates: That is a risk, but with the additional funding going into the NHS over the next two or three years it is a case of rolling out improvement as and when we can. All we can do is target the initial developments on the areas of greatest need and then cascade those out to other areas over time. I am not aware of any policy which you are suggesting in terms of trying to squeeze anybody out.

Q30 Ms Johnson: I should like to start by talking about the role of the local authority and the important role that I think they should have within this structure. I was interested to see in the Report that there is only one local authority which is actually a shareholder and I think that is Barnsley. Do you have any comments about the role that local authorities could or should be playing and are not at the moment?

Mr Coates: May I ask Brian to answer the question about local authorities' involvement in LIFT now as opposed to when the Report was written?

Mr Johns: Things have moved on since the Report was undertaken by the NAO. I am aware of four localities which have local authority shareholding already. They are Newcastle, Barnsley, Doncaster and Nottingham. There may be one or two others

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of which I am not aware but at least those four do have shareholdings. I fully agree with your question. We think it is absolutely vital to get the joined up working between primary care trusts and local authorities. Referring back to the Burnley scheme, that is actually an integrated scheme which is both health provision and also a sports centre for the local population. The strategic partnering board encourages that joint strategic planning between PCTs and local authorities.

Mr Coates: You do not have to be a shareholder to invest in local authority accommodation. It does not necessarily follow that you have to be an investor to get in.

Q31 Ms Johnson: I wanted to ask about that because, as you were saying, you can become a tenant of the premises as a local authority without being a shareholder. Are most local authorities taking up the option?

Mr Johns: I could not quote exact numbers but the majority of local authorities have signed up to the partnering agreement, that is the long-term agreement, which means that they can actually commission the schemes from the LIFTCo. As Mr Coates said, they do not actually have to be shareholders in the company to have that facility. The majority have taken that option and, having done that, they can be tenants in LIFT buildings going forward.

Q32 Ms Johnson: I want to refer you to paragraph 2.5 in the Report which talks about the constraints preventing the full involvement in LIFT which local authorities have found. What were these constraints and have they started to be addressed?

Mr Coates: I think the constraints relate to their own corporate governance arrangements within the local authority. There are no barriers of which we are aware to prevent local authorities becoming shareholders within LIFTs. My recollection of the Barnsley transaction is that the local authority there did seek legal opinion on whether they were entitled to invest or not and eventually came to the conclusion that they could do so. There are obviously the usual things about change and doing things differently. All we can say is that over time local authorities have become more accustomed to the idea of LIFT and you often see articles now in papers and periodicals written by the 4Ps, local authority advisory group encouraging local authorities to participate in LIFT and become more fully involved in it.

Q33 Ms Johnson: So there are no structural barriers, it is just a perception that this is not how they have operated in the past.

Mr Coates: Not that I am aware of.

Mr Stewart: There is one practical point which is that when the LIFTCos are set up for the first time there are the sample schemes which are bid on. In practice the local authorities have not had a very significant involvement in these sample schemes, but they will have a much greater involvement downstream. They are looking at a LIFTCo and

they are wondering whether they are involved, whether it is worth putting their equity in and becoming a shareholder in the LIFTCo from day one, probably thinking it is not really and that they can sit on the strategic partnering boards. That is the very practical consequence of the makeup of the first schemes.

Q34 Ms Johnson: What interests me about this is the idea that you can bring together the primary care sector and the care sector that the local authority provides. Is there any kind of condition or coercion about making these two work together in a more coherent way? At the moment it just seems to be left that if people feel this might be helpful they will do it. Is there a way of making people work together?

Mr Coates: We have to provide a framework within which the local communities can work together and deliver services on a collective basis. I confess I cannot answer questions about any specific examples where we can give incentives to the voluntary sector. We obviously have good examples locally where people have come together, but all these things depend on the gradual learning from others who do successfully involve the voluntary sector, for example. There is no framework here.

Q35 Ms Johnson: May I turn to GPs? I want to ask about the extent to which you think that LIFT will contribute towards an increase in recruitment and retention of GPs?

Mr Coates: There is evidence from the LIFTs we have, indeed we heard it from our visit on Thursday, that people generally, not just GPs, want to come and work in LIFTs because of the buildings, because of the better quality facilities, but we are collecting no data to try to demonstrate whether that is the case or not.

Q36 Ms Johnson: So it is just a feeling that it might help.

Mr Coates: We do have evidence from individual LIFTs saying that it is helping recruitment and retention, but we do not try to collect data in that area.

Q37 Ms Johnson: Why do you think that there is a problem with dentists and opticians being interested in getting involved in LIFT?

Mr Coates: I think in the Report it was their associations which said that rather than the individuals. All we can say is that when we try to have those facilities within our buildings by and large we are able to attract the tenants and the one you saw last week did have both optometrists' and dentists' facilities.

Q38 Ms Johnson: I was also interested that in the Report there is mention about PCTs having to subsidise rents to meet the wider health agenda. I think it is paragraph 2.14 of the Report. How often is that happening and is this an indication that rents are too high?

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Mr Coates: It is partly a reflection of the ability of the location to attract enough of these businesses and certainly for chemists there is the ability for the PCT to subsidise the rents. It is one of those areas and situations where it is up to the local PCTs to talk to the health economy more widely and demonstrate the benefits of bringing together these services on one site.

Q39 Ms Johnson: What is concerning me is that again this might be taking money away from the local health economy to subsidise rents; that concerns me somewhat.

Mr Johns: The way the PCTs look at it is that they see pharmacists as part of primary care. Pharmacists can provide a substantial amount of assistance to GPs in the work they do and it is in those circumstances that PCTs have elected to provide some sort of subsidy for the pharmacists to come in there. If that were not the case, because the pharmacy has the opportunity of over-the-counter sales and that opportunity does not exist for GPs, the LIFTCo could be charging a more commercial rate for the pharmacy. If the pharmacist is assisting the GP to provide primary care services, then in those circumstances the PCT may subsidise part of that rent.

Mr Coates: However, we do accept your point that there is this perception that as you develop one area it seems to suck resources in out of other areas. All we can say is that there is record funding going into the NHS and over time these things will equalise.

Q40 Ms Johnson: Just switching a little bit, I want to ask you about the non-executive chairmen you are appointing. The Report is indicating that there is a problem with recruitment and at one stage one of the LIFTCos did not actually have a chairman. What is the problem about recruiting somebody to be a LIFT chairman?

Mr Johns: I do not think there is so much of a problem. When the Report was written by the NAO, there was certainly one area which had not appointed a chairman of the LIFTCo and that changed afterwards. They have had a chairman. The task for the LIFTCos is to make sure that they get a chairman who has the appropriate skills to balance the public and the private sectors on the boards of LIFTCos to make sure that fair play is seen for both sides. I think the Report notes that inevitably a lot of hard work was put into place to get the LIFTCos established in individual areas and to get the individual schemes closed. People's attention focused more on that and they did not focus attention on getting chairmen. Since then we have chairmen of both the LIFTCos and strategic partnering boards across the country.

Q41 Greg Clark: The funds committed by central government are in the region of £195 million to kick-start the initiative as I understand it. Why are they needed?

Mr Coates: First of all there is the very simple incentivisation point to encourage economies to think of new ways of doing things and one of the

most successful ways of encouraging change is to provide funding to help that. More importantly, these things often require strategic change and major investment at the beginning of the process to allow, for example, land to be bought to build new facilities on. It is as simple as that.

Q42 Greg Clark: If it is for land for facilities to be built on, then it is not kick-starting, I assume that would be the case in any rollout of a LIFT.

Mr Coates: I accept that point, but I think the point I am trying to make is that when you have a new initiative you do tend to meet similar obstacles around why things cannot be done and one of them is that they do not have the money to do X, Y or Z. So we try to anticipate that by making sure money is available to help these changes happen.

Q43 Greg Clark: This is an important point about the sustainability, is it not? This is kick-start funding, then there may be a case to provide some funds to publicise it, to get people to know about it. If the funds are actually needed to buy the land to make it viable, then why can we assume that this will not be necessary in any future rollout of the programme?

Mr Coates: The wave we have just announced, the fourth wave, does include the same degree of enabling money as the first three waves. The thing which has changed, perhaps to get underneath your question, is that when we started the new LIFT initiative the tendency was to keep central funds for these things in terms of very large central budgets to facilitate change. Since then these budgets have now all been devolved out to the NHS and if similar programmes were envisaged we would expect local economies to fund much more of the enabling work and our money would be much more around the edges rather than the core of making things happen.

Q44 Greg Clark: You changed the terminology from "kick-starting" to "enabling". Does this accept that actually these programmes are going to need funding for the purchase at least of the sites on an ongoing basis?

Mr Coates: I personally do not see any difference between "kick-start" and "enabling".

Q45 Greg Clark: There is no difference between them.

Mr Coates: No. In my own terminology it is to make things happen.

Q46 Greg Clark: If it has been kick-started, it is now enabled and there is no reason at all for changing.

Mr Coates: I am sorry, I do not see a difference. In my terminology enabling money is a way of kick-starting initiatives.

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Q47 Greg Clark: So it is all the same.

Mr Coates: Yes, in my terms.

Q48 Greg Clark: Does the kick-starting/enabling money continue then for the full rollout of the programmes as far as you see it or is it just for these early phases?

Mr Coates: Just the early phases.

Q49 Greg Clark: According to the Report you expect to get the money back.

Mr Coates: When we started the process we did reserve the right to take money back to prevent silly use of it all and unnecessary use of enabling money, but the reality is that only a very, very small amount of money had been taken back from the PCTs. The only one I am aware of is that £½ million was taken from Newcastle, who said they had no need for the money, and reallocated to Plymouth.

Q50 Greg Clark: How much money has been taken back so far?

Mr Coates: £½ million. That was re-allocated to Plymouth from Newcastle.

Q51 Greg Clark: Over the maturity of the projects what percentage do you expect to be taking back?

Mr Coates: None. Having gone, it has gone. We are not going to take it back at the centre.

Q52 Greg Clark: But you have taken £½ million back to recycle.

Mr Coates: Yes, that was in 2004–05. At the end of each year we do an application of funds test, how much money has been spent, and at the end of 2004–05 Newcastle volunteered that they had funds they could not expend on enabling work. That money was re-allocated to Plymouth on the basis that they had a need, but there is no programme to recover these funds and now they have gone out to the NHS they will stay there.

Q53 Greg Clark: Just thinking about the PCTs' additional rent subsidy, what is the total value of subsidy paid by PCTs to LIFTs so far?

Mr Coates: I am afraid I cannot answer that question. I do not have the information with me and if you want it I shall have to give you a note I am afraid.

Q54 Greg Clark: Is it in hundreds of millions, tens of millions, thousands?

Mr Johns: When you say "paid in subsidies to LIFTCos"—

Q55 Greg Clark: Yes, paragraph 2.14 of the Report says that PCTs have sometimes had to subsidise occupants of the LIFT premises in order to persuade them to go in.

Mr Coates: I think this is in relation to pharmacies in particular. This is not a particular power for LIFT, it is a power PCTs have generally to allocate funds to support pharmacies in areas. I have no

idea, and I am not sure we collect the information centrally, how much is actually paid out by PCTs in this area.

Q56 Greg Clark: Sir John, did your investigators put a figure on this? This is a significant use of public funds.

Ms Leahy: No, we looked at six case studies in detail and in some of them subsidies were given, though I am not sure that we knew at the time exactly how much would be given. It was a decision in principle. My recollection is that it was relatively small amounts of money compared with the overall total.

Q57 Greg Clark: How big? How much is "small" in these circumstances?

Ms Leahy: I do not have any specific figures though I am sure that I could go and find them.

Sir John Bourn: We could, with the witnesses, let the Committee have a note on that.³

Q58 Greg Clark: We have a situation in which, in order to make the schemes work we need funds from central government, kick-starting/enabling funds. We sometimes need funds from PCTs to subsidise the operations, but we do not know how much, all of which come from health expenditure totally. We have a situation in which GPs, according to the Report and according to Dr Kohli here, are not always enthusiastic about the costs of the premises; they need to be persuaded to go in them. In fact paragraph 2.14 of the Report seems to have quite an extraordinary approach. It says "There is a common perception from these groups of prospective tenants that the higher cost of LIFT, compared to current rent payments, outweighs the benefits". But then the next line takes us into a strange realm. The response to this seems to be "The Department worked hard to address this through creation of GP champions for local areas and by hosting forums for GPs to understand the issues". Could it not be the case that actually GPs do understand the issues and they do not think these are terribly good value for money? Appointing champions is not the way to address it: we need more effective scrutiny of these costs.

Mr Coates: If GPs generally feel that these facilities are too expensive, I think the result would be that we would find it impossible to find tenants for the properties over time. The evidence is that once negotiations open between GPs and the PCTs about the benefits of a location and co-location, GPs are persuaded that any additional cost is worth the investment.

Q59 Greg Clark: Is not the truth that the reason they are persuaded is that they have to be bribed in effect, using health funds which might be spent on waiting lists. My own PCT has long waiting lists for various procedures and I should be alarmed if this was actually being spent persuading GPs to make a rational assessment of the costs, to decide

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that the rent is unaffordable, that these limited funds are being used to persuade people to go into bright shiny buildings rather than getting tests for people who are on waiting lists.

Mr Coates: I do not see this as a bribery issue; I see it as a case for enabling the health economy to make changes.

Q60 Greg Clark: The “enabling” word again.

Mr Stewart: One thing to point out is that one of the objectives of LIFT was to put decent facilities in deprived areas and in that sense it was addressing a market failure. These facilities are generally going to deprived areas where the third party developers were not prepared to invest. In that sense we were not dealing with an economic market situation, we were dealing with market failure and therefore in that sort of situation enabling funds are appropriate.

Q61 Greg Clark: I assume that these were not areas where there were no GP surgeries.

Mr Stewart: No, but they were extremely rundown and there was a reluctance on the part of GPs to invest. We always joke about the leafy suburbs of Surrey where GPs are prepared to invest in their properties; it is indeed part of their pension. The majority of the investment in LIFT has gone into deprived areas where that sort of investment is no use.

Greg Clark: Everyone wants a bright shiny new surgery and Dr Kohli has said how delighted he is with his, but some hard choices have to be made and I am not sure there is enough transparency between the allocation of funds into shiny new buildings and providing a more day-to-day treatment of patients.

Q62 Jon Trickett: I am really very uneasy about this Report. I do not think it demonstrates value for money and we are meant to be a value for money committee. There appear to be two references to this and I am going to put all my questions to Sir John or his assistant. Paragraph 2.21 says “... value for money has largely been demonstrated by there being a competitive procurement” process in the main. So we are resting the proof of value for money on the fact that there is competition. Then at the end in Appendix 1, under Methodology, it says in paragraph 4 “The local LIFT models appear to be an effective mechanism clearly demonstrating value for money”, but that is not the conclusion of the NAO, that is the conclusion of a kind of focus group type of operation called a Dinner Party. When you read the Report carefully it is actually bereft of financial analysis frankly. I read it twice and then I went to the methodology and in the methodology there is only one reference to financial analysis, the rest of it is qualitative analysis based on focus groups, expert panels, case studies and the case studies are just looking at document reviews and interviews with stakeholders. The vast bulk of the work which has been done has been qualitative. Paragraph 6 in the appendix on methodology talks

about Operis. This firm appears to have been sub-contracted by the NAO to do the financial analysis. Why?

Ms Leahy: Operis is a firm which specialises in looking at financial models and we do not have that specialist expertise in-house. We contracted with Operis to carry out a number of analyses on the basis of the information we had available and then there was a dialogue. They did not just produce information which we put into the Report.

Q63 Jon Trickett: How many contractors were invited to tender for this work by the NAO?

Ms Leahy: We appointed them on the basis of a framework agreement that we had with them which meant that because it was for a relatively small amount of money we did not have to go out to tender.

Q64 Jon Trickett: As I thought; there was no tendering process yet the NAO rests the whole of its financial analysis basically on an iterative process with Operis where they appear to have been the sub-contractor. Was the NAO aware of the work which Operis does on LIFT schemes throughout the country?

Ms Leahy: Yes.

Q65 Jon Trickett: I just went to the Operis website 20 minutes before this meeting started and I discovered that on 30 September they advised a range of banks and other financial institutions on the Doncaster LIFT scheme, on 24 May they advised bankers and other private sector people on the Medway LIFT scheme and on 9 February they advised the same groups of people on the East Hampshire LIFT scheme. It seems surprising to me that we have not been out to tender, yet we have delegated the whole financial analysis to a company which is up to its neck in LIFT schemes, supposedly to advise us on an analysis of LIFT. How can it be that a company which is involved in LIFT schemes was used by the NAO to give the Committee of Public Accounts an appraisal of the content of LIFT schemes? How can that possibly happen?

Ms Leahy: They ran the analysis through standard models and it was basically a mechanical exercise that they do very often and are familiar with and they gave the output to us. We have checked—

Q66 Jon Trickett: You used a student at a university to assist you with your financial analysis of the Operis scheme, did you not? This appears to be another sub-contracting. Did we pay Mr Arshad Mahmood?

Ms Leahy: He received a very small amount of money for the work that he did, but he did not check the Operis work, it was additional to the work.

Q67 Jon Trickett: Did it not occur to you that the Committee of Public Accounts has to be above and beyond reproach and the advice we receive, which is to Parliament and therefore the taxpayer, has to

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be absolutely unimpeachable. You employ 700 or so accountants. How is it that we have chosen a company which is involved in a whole range of private sector schemes, but particularly LIFT schemes, to do the analysis of LIFT? How can that be? What reliance can we as Members put on this Report?

Ms Leahy: I am sure you can rely on those figures. I am confident—

Q68 Jon Trickett: There are no figures.

Ms Leahy: I am confident that those figures are accurate figures.

Q69 Jon Trickett: Which figures?

Ms Leahy: The figures in Table 10 which came from the Operis report, the internal rates of return (IRR) percentages and the residual value. These figures came from putting numbers that we obtained through a model to get consistent information from the different parties.

Q70 Jon Trickett: Let me ask you this. There are other ways of funding GP surgery buildings and the normal procedure for the NAO to advise the Committee of Public Accounts is to test what the market is saying against a public sector comparator. Why is there no public sector comparator?

Ms Leahy: These schemes do have public sector comparators. We did not put that information here because value for money is not just the cost side of it and the costs over the period we are looking at would be very uncertain. Our definition of value for money which we put in the Report is a mixture of the whole life costs of the project compared with the benefits and the quality one can get—

Q71 Jon Trickett: At the end of the day, certainly I as a Member of this Committee, expect to be able to have some kind of financial analysis. I accept that value for money is all about quality of service delivery, but with Dr Kohli saying that the costs of the scheme, and generally this is a GP view, tend to be very high and the fear therefore that money is being diverted into LIFT schemes from other types of financing I would have thought you would have thought that the Committee would be interested in the financial implications. In the London improvement zone mainstream NHS grant funding is available for enhancements to GPs' surgeries. What analysis have we done as to the cost of that relative to the cost of the LIFT scheme? Surely it would have been a direct real life comparison for us to analyse whether LIFT was giving us value for money in financial terms or not?

Ms Leahy: The private development schemes are usually done in many different ways.

Q72 Jon Trickett: This is not a private development, this is NHS grant, mainstream funded. Has any work been done on that? Public sector comparators can be either conceptual, as they often are, as we have debated many times, or they can be based on real life experiences. There are

real life experiences inside London. There is no reference in this Report, no evidence that the NAO was aware of that. There is no attempt to build a comparator. Frankly this document is simply unsatisfactory. I could not possibly say, nor could anybody frankly, that this document demonstrates value for money. Mr Coates actually said—and I wrote down his words—"We will not know for some time whether value for money and success have been achieved" or not. Those were Mr Coates's own words; I wrote them down. Given that statement, does this Report, in your mind, demonstrate value for money? Sir John, I want to put you on the spot.

Sir John Bourn: I think you make some good points about our financial analysis and I recognise that, although Ms Leahy has given some replies, we have not been able to take you with us. I will also say that we do echo your fears and also what Dr Kohli said because we have mentioned, for example in recommendation 9, the importance of actually evaluating whether these projects do turn out to provide value for money. We may not have been able to convince you that so far they have, but we certainly stand with you on the need for a framework, an evaluative arrangement to see how they work out in practice and to Report to the Committee on whether they work out well or badly.

Q73 Jon Trickett: Is it possible that you knew what the answer would be if you did a financial appraisal and therefore you have adopted a methodology which actually avoids posing the very difficult questions as to whether these are developing value for money at all? That is the conclusion I have come to. You have side-stepped it.

Sir John Bourn: That is not how we approached it, but I take the points you make and I shall reflect about them.

Jon Trickett: I just feel that this NAO Report takes a major step, a step change from quantitative analysis based on a financial appraisal through to a qualitative analysis such that it is impossible for this Committee to express a view. Here we are asking a range of stakeholders, all of whom have a stake in the success of this scheme, what they believe has happened. These are the views of people. It is not an objective quantitative appraisal of the kind I would expect to come before this Committee. I protest actually about the way this has been put before us. Certainly I shall not be agreeing to this.

Chairman: Is that a fair criticism, Sir John? We do not often have this sort of questioning put to you and that is why it is very important that it is taken very seriously.

Jon Trickett: Particularly, Chairman, given the fact that we have used a contractor who is up to his neck in the LIFT schemes to advise the Committee.

Q74 Chairman: Is there anything more that you feel you could have done to provide some quantitative as opposed to qualitative assessment to this Committee?

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Sir John Bourn: I would defend the use of a contractor. The fact that a contractor works in an area means that he becomes expert in it and it does not mean to say that he is only concerned with one of his customers. He is a professional person and he is concerned with a range of customers. I take the point that one could have taken a number of particular schemes and compared the cost of those with the ones which have come out of LIFT and one could certainly have done that. Of course what you would have had would have been a range of schemes which cost different amounts of money, partly perhaps because they were funded in different ways, but partly also because they were in different circumstances. One of the points about the whole of PFI in the National Health Service is that the government does not say that PFI is going to be cheaper. It recognises this and is prepared to pay over the odds to get it. Clearly I regret the fact that we have not taken Mr Trickett with us, but I would also make the two points that I have mentioned: you are going to find in some of these schemes that they are going to cost more doing it that way. We have also said that for the future it is necessary to have an evaluative framework which does not exist yet. I accept that we could have done this better, but I argue that the main points are there and ones which ride into the future justifiably.

Q75 Jon Trickett: It is not for the NAO or PAC to get involved in policy or ideology. If the government decides it wants to do something which is more expensive, for whatever reason, than other ways of doing it that is up to the government. However, we are entitled and in fact should express an opinion as to the additional cost that policy incurs. That is our role and we ought not to duck it.

Sir John Bourn: I will say that I am quite happy to come back to the Committee with a supplementary report which would have the list of schemes which had been funded directly by the NHS. I am happy to come back and put that information before the Committee.

Chairman: That would be very useful; before we consider our Report.⁴

Q76 Mr Bacon: I must say I have a limited amount of sympathy for the NAO's position, particularly relating to the public sector comparator, because this Committee has often criticised the public sector comparator. I suppose there is one sense in which you are damned if you do and you are damned if you do not, but it does seem to me that the answer to that is more information rather than less. I was slightly perplexed by one of Ms Leahy's answers. You described the financial modelling process as a standard, rather mechanical one. It did occur to me that if it is standard and rather mechanical, why is it that there is no in-house expertise and it has to be farmed out?

Ms Leahy: We do have some in-house expertise, but we did not have it available at the time to do that. The resources were tied up at that time when

we needed them and Operis were available and they do the sort of analysis that we wanted day in day out. We have used them for that sort of analysis in the past and it seemed good value to us to go to them rather than use other resources which could have been used on higher priorities in the National Audit Office. We saw it as a very straightforward low key decision to do that.

Q77 Mr Bacon: This is obviously a financial committee and these are called finance trusts. Can you tell me where in the Report there are tables referring to millions of pounds spent?

Ms Leahy: We do have the information on the plans for spending under LIFT for the six case studies in particular which we looked at for the Report. We concluded that what mattered for value for money were having a competition, a competitive procurement, looking at the finance terms which we have in a table in here, the cost of the debt.

Q78 Mr Bacon: So you thought it was better to put in the cost of the debt. Actually you have put it in. I was just checking whether there was anything else I did not know about, that I missed, other than page 38 where there are some numbers. I had to dig around to find them, but they are in Appendix 2 on page 38. A capital sum is given for each of the various case studies. I personally would have preferred more of that sort of information, only in more detail, further up, but that is where I eventually found it. You put the point very succinctly earlier when you said that value for money is a mixture of the costs over the period, over the whole life costs, together with the benefits and the quality. I put that even more simply and it is essentially what this Committee spends its whole time looking at, namely, bangs for your buck. That is the real question. It is not whether the centre that Dr Kohli works in is or is not marvellous. I went to have a look at it the other day and it is marvellous and Dr Kohli himself told us what a pleasure it is to work there, how easy it is to attract staff, there are regeneration benefits, which I shall come onto if we have time, but it really is about bangs for the buck, how much you can squeeze out of the lemon. Dr Kohli, you have some experience of running other GP practices with GP partners in buildings which you yourselves owned before you came into the LIFT scheme. Is that right?

Dr Kohli: Yes.

Q79 Mr Bacon: Could you say how many partners, how big the building was?

Dr Kohli: In 1990 I was a partner in a practice called Market Street Health Group where we had five partners and we built on a brownfield site something very similar to a LIFT concept. In this Report it is called a third party development, but actually we called it cost rent. Cost rent is in my world the original LIFT project. It was a device where GPs were incentivised to build and own and develop high quality premises. They were then the owners.

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Q80 Mr Bacon: So you took the risk yourselves.

Dr Kohli: You took the risk yourself, you borrowed the money yourself and the health authority, whichever that happened to be, would give you an annual rent based on your cost to build based on a basic base rate, usually 1% above base rate. You build for £1 million and you get it for 6% and you would be quite happy with that because you would get it for 20 years or 25 years at the end of which the building is yours. You are 100% responsible for all hard FM: repairs, maintenance, the whole caboodle. Relative to that, which could still happen because they have not banned cost rents, a scheme like this which for our building cost nearer 20% per annum—I do not know about others—does seem exceedingly expensive.

Q81 Mr Bacon: 20% instead of 6%.

Dr Kohli: Yes. 6% would be the base rate you would give and you would give 10% for hard FMs and you would get 6.6% under normal cost rent rules. That is the concern: it is stifling other opportunities because more money is being diverted to pay for these new developments.

Q82 Mr Bacon: You are saying that there might have been other money available to pay GPs to do cost rent schemes had it not been diverted in this direction. What about Mr Stewart's point that in certain areas like where we were in Newham, it is not necessarily obvious that GPs will pile in or put their own property or their own house at risk because it is not a pension in the way that it is in leafy Surrey. Would you have gone into a cost rent programme in somewhere like Newham?

Dr Kohli: When I was part of the scheme with five doctors in 1990 the property market was in dire straits and it was a big financial risk and we were all in negative equity for many years; infinitely more so than today. It was a very different climate. Today, with the property market in East London, which is all I know, having risen so much the affordability is there. It is where the property has no value that there is no point and you cannot afford to build new. Today you can in East London and local practices would. What they cannot do, what LIFT does give, is the next stage on, which is just beyond the GP's surgery: co-location, the different providers working together. That is the new thing which LIFT bought and that is what I got excited about, as I have written in my statement, and that is why I was so attracted to it. Like a lot of other GPs I am also equally struck by the costs and whether we can afford the other 10 buildings we need in Newham to do what we set out to do. If you read the original LIFT documentation in the strategic development plans, we were supposed to transform 30% or 40% of our entire premises stock within three to five years. It could be done but the affordability is not there.

Q83 Mr Bacon: Mr Coates, on the subject of an excellent LIFTCo building like the Newham one, I understand that LIFTCo has basic responsibility for how this building is built, developed, operated and managed. That is basically right, is it not?

Mr Coates: Yes.

Q84 Mr Bacon: Is that "except for IT"?

Mr Coates: As I understand the original agreement as struck, IT was left for the PCTs to settle with the GPs.

Q85 Mr Bacon: So if Dr Kohli wants to send an e-mail on one local area network to the psychologist next door or to the dentist next door but one, as we saw will be possible physically, he cannot, he has to write to them because there is no local IT solution which would work for one building. It would not require a particularly complicated IT system because you are talking about how many professionals in the building altogether?

Dr Kohli: Eighty staff.

Q86 Mr Bacon: So we are talking about a relatively small- to medium-sized business, a very easy thing to do in terms of off-the-shelf IT and of course with the expertise that GPs have of developing user-friendly IT for themselves over the last 20 years it would not have been that difficult, yet you do not have that at all, do you?

Mr Coates: May I ask Dr Kohli why it has not been resolved?

Dr Kohli: To be fair we do have internal e-mail, which is rather different from having a shared IT system. The point I made earlier was that if we want to refer to one of the visiting consultants downstairs we do not just make an internal e-mail referral, you actually have to write back up to the hospital where the outpatient department happens to be and to be fair that is not really within LIFT. That has been nationally procured through an IT system and I suspect that is another debate altogether.

Q87 Mr Bacon: Are the consultants you have downstairs just occasional visitors or are they quasi resident inasmuch as it is the same ones each week?

Dr Kohli: No, the same people come every week for a clinic a week and not just them but also GPs with special interests who are community specialists.

Q88 Mr Bacon: So the referrals could be handled locally.

Dr Kohli: Follow-ups can be made locally and are made locally. It is the new appointments, because the system is all run through central operations. Even that is not the problem. The problem is that you cannot view it and you still have to write a paper record to the hospital. It is more like an outreach of the hospital as opposed to being joined up with community services and that is an evolution which is going to take some time.

Q89 Mr Bacon: I noticed, like Mr Trickett, the reference on page 36 to the IADP, the Issue Analysis/Dinner Party statement, what you call a high level conclusion, "The local LIFT models appear to be an effective mechanism clearly demonstrating value for money". Then, in

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paragraph 2.32, the sentence “Given the newness of the initiative and the importance of strategic factors that are not easily quantifiable, conclusions about the likely longer term value for money of LIFT are likely to be judgemental”. I simply do not know, like my colleagues, whether this really is value for money or not. My question to you is: is this value for money, is it not value for money, or is it too early to say?

Mr Johns: I believe the simple answer to that question is that it is value for money and every LIFT deal that is signed has to be agreed by the Valuation Office and the Valuation Office of course have access to data on all developments for primary care, GP third party developments and LIFT and public sector schemes as well. Before they sign up the value for money of any LIFT scheme they do a comparison with a third party development. As Dr Kohli has intimated, that is not a straightforward comparison because LIFT tends to deliver a much broader, more complex range of services than a simple GP third party development. Against that background the Valuation Office do undertake a review and no LIFT business case can be approved without that Valuation Office approval of value for money. That is the first step. Because LIFT is innovative we cannot just look at what the costs of the schemes are: we also have to look at the value of the services provided and the benefits to patients. That does take longer to get a full long-term assessment.

Q90 Mr Bacon: Is it not therefore fair to say—I am not trying to be difficult—and therefore you cannot yet say whether it is value for money.

Mr Johns: What I can say is that in comparison with third party developments, the comparison the Valuation Office have undertaken not that we have undertaken, they determine that it is value for money. What I am saying is that we will get a much broader measure of value for money over the longer term and indeed we are undertaking work now with LIFTCos to investigate not only the cost of providing the facilities, but the benefits to patients and the benefits to health outcomes which ultimately is what drives value for money, not the premises but the health outcomes that we derive.

Q91 Mr Bacon: Sir John, is it fair to say that the National Audit Office, from the rather tentative nature of that sentence in paragraph 2.32, is a little more doubtful whether it can yet be demonstrated that it is value for money? It is plainly shiny, it is plainly a high quality environment, but on the principle of bangs for one's buck can we yet say that this is value for money?

Sir John Bourn: No, we cannot say that, as paragraph 2.32 and also recommendation 9 say when we call for a proper system for evaluating it. All you can talk about is where you have got to now; you cannot talk about how it will develop for the future, that is right.

Q92 Mr Bacon: Do you share Mr Trickett's concern and indeed Dr Kohli's that this could be extremely expensive and that there might be better value for money ways of doing the same thing or something similar?

Sir John Bourn: I certainly do, from what I have said before, because you can see that implicit in this way of doing things are extra costs. Of course the argument is that from the extra costs you will get different and better services. In that sense you are not sure how you are comparing like with like. Certainly, as we would look at this as the programme developed, we would be able to say and give a clearer view, particularly if the witnesses accept the recommendations, as they said they do, that they need to have a machinery and methodology for evaluating it.

Q93 Mr Bacon: On page 38, where there is the reference to the capital value of each project, for example in the case of East London and City £5.5 million and it refers to a population of 666,000 people, am I right in thinking that 666,000 people is all the people within that PCT, not all the people who are covered by this project? That is right, is it not?

Ms Leahy: That is right. The population in Newham PCT is about half the 666,000 population there and these schemes cover a small part of the population.

Q94 Mr Bacon: Surely the interesting number is not 666,000 but the list size covered by the project in the way that Dr Kohli has done on his extremely helpful chart,⁵ one of the most helpful charts I have seen on this whole project, where he comes up in a fairly simple but difficult to dispute way with a calculation of the cost per patient. He says that in the Manor Park LIFT site there are 14,400. That is your list size at your facility.

Dr Kohli: In three practices who are in the site.

Q95 Mr Bacon: Within your site?

Dr Kohli: Yes.

Q96 Mr Bacon: Surely it is the 14,430 patients compared with the £5.5 million which is relevant not the 666,000 compared with the £5.5 million, is it not?

Ms Leahy: Perhaps we should add in more information.

Q97 Mr Bacon: Is it possible that we could get for each of these the number of patients in the lists covered by those LIFT projects? So for the £10.3 million for Barnsley, the patients covered under that LIFT project, ditto for the other six and perhaps you could go a stage further and do something similar to what Dr Kohli has done there so we can compare the cost per patient at each of the sites and also the number of patients who are not covered, in Dr Kohli's case 270,000 or so.

Ms Leahy: We certainly will get that information and put it to you.⁶ The cost analysis that is there is

⁵ Ev 17–18

⁶ Ev 20–22

Department of Health, Partnerships for Health, Partnerships UK and Dr Kohli

very much an apples and pears comparison in that the cost of the LIFT schemes include quite a lot more than the costs just in the rent which was quoted. A pure replication of that analysis probably would not be helpful to the Committee, but I am very happy to see whether I can work out how to close the gap to try to get comparable information.

Chairman: I am grateful to the Committee and to you gentlemen for appearing before us. We are a value for money committee and I am very grateful to Mr Trickett and to Sir John for promising a supplementary report. It is clear that we are producing marvellous facilities as far as the general public is concerned and Dr Kohli has made that clear, but we also have to investigate much more fully whether we are getting value for money. Thank you very much.

Memorandum submitted by the National Audit Office

KEY LIFT STATISTICS AND DATA AS AT SEPTEMBER 2005

As at September 2005:

<i>Public body</i>	<i>Status</i>	<i>Preferred bidder</i>	<i>Date preferred bidder appointed</i>	<i>Financial close date</i>	<i>Buildings open to patients</i>
<i>First Wave</i>					
Barnsley	LIFTCo established	Community Solutions for Care	19/02/2003	30/01/2004	Goldthorpe— Dec 2004 Worsbrough— Dec 2004 Thurnscoe— Dec 2004
Camden & Islington	LIFTCo established	Community Solutions for Care	23/05/2003	16/07/2004	Hanley Road— June 2005 Bingfield Street— Aug 2005
East London & City	LIFTCo established	Global Solutions/ Babcock & Brown	05/12/2002	End-May 2003	The Centre Manor Park— Sept 2004 Boleyn Centre, Barking Rd— Aug 2005
Manchester, Salford & Trafford	LIFTCo established	ExcellCare Ltd	16/04/2003	01/07/2004	
Newcastle and North Tyneside	LIFTCo established	Robertson	28/05/2003	11/05/2004	Brunton Park— March 2005 Shiremoor— March 2005 Walker— June 2005 Kenton— Sept 2005
Sandwell	LIFTCo established	ExcellCare Ltd	11/04/2003	15/01/2004	Birmingham Rd Health Centre— April 2005 Oldbury Sept 2005
<i>Second Wave</i>					
Barking and Havering	LIFTCo established	Primaria	May 2003	04/12/2003	Thamesview— April 2005 Broad Street— June 2005
Birmingham & Solihull	LIFTCo established	Carillion Prime	11/06/2003	21/07/2004	Chelmsley Wood—July 2005 Woodgate Valley—July 2005

<i>Public body</i>	<i>Status</i>	<i>Preferred bidder</i>	<i>Date preferred bidder appointed</i>	<i>Financial close date</i>	<i>Buildings open to patients</i>
Bradford	LIFTCo established	B & N Group Ltd	17/11/2003	19/10/2004	
Cornwall & Isles of Scilly	LIFTCo established	1st Health Solutions	22/08/2003	24/05/2004	Liskeard Health Centre— June 2005
Coventry	LIFTCo established	GB Consortium	25/09/2003	08/12/2004	
East Lancashire	LIFTCo established	Eric Wright Group	11/06/2003	24/10/2003	Bacup— March 2005 Nelson— May 2005 Darwen— June 2005
Hull	LIFTCo established	Sewell	05/09/2003	20/09/2004	Marfleet— Sept 2005
Leicester City	LIFTCo established	ExcellCare Ltd	15/08/2003	18/08/2004	
Liverpool & Sefton	LIFTCo established	GB Consortium	13/11/2003	18/06/2004	Ainsdale— June 2005 West Everton— July 2005 Litherland— September 2005
Medway	LIFTCo established	Ryhurst	07/01/2004	24/05/2005	
North Staffordshire	LIFTCo established	Prime	04/11/2003	03/02/2005	
Redbridge & Waltham Forest	LIFTCo established	Ryhurst	May 2003	05/08/2004	
<i>Third Wave</i>					
Ashton Leigh & Wigan	LIFTCo established	Eric Wright Group	18/09/2003	31/01/2004	Atherton— January 2005 Lower Ince— May 2005 Worsley Mesnes— July 2005
Barnet, Enfield & Haringey	LIFTCo established	GB Consortium	07/11/2003	15/07/2004	
Brent, Harrow & Hillingdon	LIFTCo established	Global Solutions / Babcock & Brown	06/10/2003	22/12/2004	
Bristol	LIFTCo established	Infracare (South West) Ltd	12/08/2003	07/05/2004	
Bromley, Bexley and Greenwich	LIFTCo established	Global Solutions/ Babcock & Brown	24/11/2003	01/03/2005	
Colchester & Tendring	LIFTCo established	Mill Group	07/11/2003	07/07/2004	
Doncaster	Preferred Bidder	Community Solutions for Primary Care (CSPC)	20/12/2004	N/A	
Dudley South	Preferred Bidder	Infracare (South West) Ltd	26/04/2004	N/A	
Ealing, Hammersmith and Hounslow	LIFTCo established	Building Better Health	15/08/2003	22/03/2005	

<i>Public body</i>	<i>Status</i>	<i>Preferred bidder</i>	<i>Date preferred bidder appointed</i>	<i>Financial close date</i>	<i>Buildings open to patients</i>
East Hampshire, Fareham/Gosport	LIFTCo established	Community Solutions for Primary Care	26/01/2004	09/02/2005	
Greater Nottingham	LIFTCo established	ExcellCare Ltd	17/09/2003	14/06/2004	
Lambeth, Southwark & Lewisham	Preferred Bidder	Building Better Health	14/11/2003	N/A	
Leeds	LIFTCo established	Primaria	12/12/2003	28/09/2004	
Norfolk	LIFTCo established	Guildhouse Investment Management	05/12/2003	21/05/2004	Plowright Medical Centre, Swaffham—May 2005 Sheringham Health Centre—Aug 2005
North Nottingham	Preferred Bidder	ExcellCare Ltd	03/11/2003	N/A	
Oldham	LIFTCo established	Ist Health Solutions	12/12/2003	17/11/2004	
Oxford City	LIFTCo established	Infracare (South West) Ltd	20/10/2003	29/11/2004	
Plymouth	LIFTCo established	Midas Sutton Harbour	20/11/2003	21/10/2004	
Sheffield	Preferred Bidder	Ist Health Solutions	23/12/2003	N/A	
Southern Derbyshire	LIFTCo established	ExcellCare Ltd	30/10/2003	03/12/2004	Eden Surgery—Aug 2005
South West London	LIFTCo established	Building Better Health	22/12/2003	28/04/2005	
St Helens, Knowsley, Halton, Warr	LIFTCo established	William Pears (Family Holdings)	19/11/2003	20/10/2004	
Tees Valley	LIFTCo established	B&N Group Ltd	28/01/2004	13/10/2004	
Wolverhampton	LIFTCo established	Global Solutions/Babcock & Brown	28/10/2003	10/11/2004	
<i>Fourth Wave</i>					
Bury, Tameside & Glossop	Pre-tender stage		N/A	N/A	
Rochdale, Bolton and Heywood & Middleton	Pre-tender stage		N/A	N/A	
South East Essex	Pre-tender stage		N/A	N/A	
South East Midlands	Pre-tender stage		N/A	N/A	
South Midlands	Pre-tender stage		N/A	N/A	
South West Hampshire	Pre-tender stage		N/A	N/A	
Sustainable Communities in Kent	Pre-tender stage		N/A	N/A	
Wiltshire	Pre-tender stage		N/A	N/A	

Memorandum submitted by Dr Bhupinder Kohli

I have been closely involved with the LIFT building program in East London. When the program was first launched in 2003 I was the GP representative on the selection panel for the private partner selection. At the time I was the Chair of the executive committee of the Newham Primary Care Trust. I have been closely associated with promoting LIFT buildings in our area and as a result was appointed the clinical champion for LIFT in Newham.

I was inspired by the concept of super surgeries and of the partnership between several public sector bodies and the private sector. LIFT was like a breath of fresh air the development of primary care buildings and area of neglect for many years in East London.

I was very impressed with the early stages of LIFT and the speed with which it promised to deliver the buildings. I decided I wanted to work in one of the new LIFT buildings. As a result I applied to take over a single handed retirement vacancy in the area of the new LIFT building and resigned my post in an established group practice and with the hope that this would mean I could work in the new super surgery.

Soon after this we were successful in taking over another two local single handed vaccines in Manor Park and were selected to work in the Super Surgery.

Working in The Centre Manor Park the first super surgery to be opened under LIFT is a joy as the building is by far one of the best designed primary care premises in the area. It has transformed the lives of local residents and the working lives of health workers. Although the move has been hardwork the end result has been a vast improving in the services we offer and helped in the recruitment of Doctors in a deprived hard to recruit area.

Many other practices in the area have wanted to have the same opportunity of moving into buildings like the one I work in. However the LIFT buildings are significantly higher in revenue costs than previous methods to provide GP premises like for instance third party developers.

I am not an expert in accounting but as a lay observer I am concerned at the affordability of LIFT.

The building I work in cost £5 million to build and has a service charge of over £1 million per annum which includes repairs and maintenance for the building. This is 20 year contract which is inflation linked and includes hard facilities management cost.

The two LIFT buildings in Newham that have been finished take up 33% of the budget for 8% of the population. See tables below given to me by David Stout, Chief Executive of Newham PCT.

CONCLUSION

Most of the local primary health care workers would love to see more high standard buildings in the area to replace the 35 odd premises that are significantly below standard as they are converted Victorian terraced houses. However the significantly higher revenue costs of LIFT buildings poses an affordability question for the other practices and patients of Newham. The cost of LIFT buildings is significantly higher than traditional 3rd party development and has put a stop to other forms of delivery of primary care premises.

My concern is that we will not be able to deliver the patient led NHS agenda or Practice Based Commissioning which are the corner stones of delivering the New NHS and of giving choice to patients. A problem of inequity of buildings quality to patients is a problem.

Furthermore for alterations that may be needed from time to time to LIFT buildings we have lost the ability to obtain to get a competitive quote. Traditionally in primary care when minor alterations are required we were asked to get three quotes and the best value and quality and supplier got the business. Under LIFT we have to use the LIFT landlord who has a monopoly in providing for any alterations. We have had some bills for minor works which have been significantly higher than what we are used to paying for in the community NHS. My concern is that due to cost we will not make the necessary minor alterations that affect patient care.

Analysis of General Practice premises cost in Newham 2005–06

<i>Total rents paid—Newham PCT 2005–06</i>	<i>\$</i>	<i>List size</i>	<i>£ per patient</i>
Total PMS	1,644,814	188,128	8.7
Total GMS	679,105	101,573	6.7
Total PMS and GMS	2,323,919	289,701	8.0
Boleyn Medical Centre (est full cost £574k)	476,420	11,774	40.5
Centre Manor Park (est 61% of full cost £1,084k)	661,240	14,430	45.8
LIFT sites	1,137,660	26,204	43.4
Grand total rent for GP's premises	3,461,579	315,905	11.0

<i>Primary Care premises costs</i>			<i>Population</i>	<i>Costs</i>
Total PMS and GMS	2,323,919	289,701	92%	67%
LIFT sites	1,137,660	26,204	8%	33%
Grand total rent for GP's premises	3,461,579	315,905	100%	100%

Notes

Lift rents include hard FM costs not covered in other practices.

Share of GP space in LIFT sites estimated.

List sizes based on 1 January 2005 (some estimated)

Wide variation in rent costs in GMS and PMS practices (from £2.1–£20.7)

Supplementary memorandum submitted by the National Audit Office

INTRODUCTION

During its hearing on the National Audit Office's Report "Innovation in the NHS: Local Improvement Finance Trusts" (HC 28, Session 2005–06) on 17 October 2005, the Committee asked the National Audit Office for additional information and analysis which the Comptroller and Auditor General offered to provide in a supplementary report. The following memorandum provides the information and analysis requested by the Committee.

Question 57 (Mr Greg Clark): Primary Care Trust subsidies

Mr Clark asked witnesses about the extent of subsidies paid by the Primary Care Trusts (PCTs) to tenants in the NAO's six case studies (paragraph 2.14 of the Report). The NAO offered to quantify the extent of subsidies paid in the six LIFT case study areas.

In four out of six of the case studies, the PCTs did not pay any subsidies to tenants or tenant organisations to encourage them to take space in the LIFT developments. Two did pay subsidies as follows:

- (i) Ashton, Leigh and Wigan PCT has subsidised Wigan Metropolitan Borough Council (the Wigan Council). These organisations operate a joint financing pot for some joint initiatives. The Wigan Council space in the Lower Ince development is funded from the pot from April 2005 until March 2007. A subsidy of £839,000 will be paid by the PCT over this period. From thereon the Wigan Council will pay for the space from its central funds. The PCT agreed that the pot could be used to fund Lower Ince to encourage the Wigan Council to take space in the building, which it otherwise could not have afforded. Wigan Council was thus able to be involved in the project from its inception with a two year window to find the money that it needed to fund the tenancy.
- (ii) Newham PCT in East London agreed to give a subsidy of £7,500 per annum for two years to Care Navigators to use space in the Manor Park centre. The Care Navigators are employed by Newham University Hospital National Health Service (NHS) Trust. They help people with long term health conditions access a range of health, social and voluntary care services, tailored to the individual's particular needs, to help them manage their conditions. The Care Navigators also assist with referrals around the various professionals located within the LIFT building.

Question 75 (Mr Jon Trickett): Recent primary care developments and comparators to LIFT

Mr Trickett asked how LIFT compared with publicly funded primary care facilities. No public sector comparators are prepared for LIFT schemes. The NAO agreed to provide information on schemes funded directly by the NHS for comparison with LIFT.

The NAO has produced the list below from the most detailed available information held centrally by the Department of Health (DoH). It gives information on comparable developments (ie one stop primary care centre schemes) between 2000 and 2004, prepared by the Estates division of the Department of Health, and has analysed this by the different routes under which they were procured. The funding route for many developments is not known. The list shows that 31 out of 588 developments are known to have been publicly funded.

A summary of the total developments for each Strategic Health Authority and funding mechanism, where it is known, is provided in Table 1.

Table 1**TYPE OF FUNDING FOR PRIMARY CARE PREMISES WHERE KNOWN**

<i>Strategic Health Authority</i>	<i>Total number of developments 2000–04</i>	<i>Type of development</i>					<i>Other/not known²</i>
		<i>Public</i>	<i>PFI</i>	<i>Third party¹</i>	<i>LIFT</i>		
North East London	8	0	0	0	4		4
South East London	6	0	1	0	0		5
North Central London	7	0	0	3	0		4
North West London	11	0	0	1	0		10
South West London	15	0	0	11	0		4
Kent and Medway	1	0	0	1	0		0
Surrey and Sussex	21	0	0	12	0		9
Thames Valley	18	0	0	11	0		7
Birmingham and the Black Country	28	1	0	2	3		22
Coventry, Warwickshire, Herefordshire and Worcestershire	7	0	2	0	0		5
Shropshire and Staffordshire	31	2	3	0	1		25
Cheshire and Merseyside	33	2	2	0	6		23
South Yorkshire	12	0	0	2	3		7
West Yorkshire	28	0	0	0	7		21
North and East Yorkshire and Northern Lincolnshire	46	3	8	10	0		25
Greater Manchester	18	0	0	0	7		11
Cumbria and Lancashire	14	0	0	0	7		7
Avon, Gloucestershire and Wiltshire	25	3	0	3	1		18
Dorset and Somerset	14	0	1	3	0		10
South West Peninsula	22	2	1	3	1		15
Hampshire and Isle of Wight	19	5	0	2	0		12
Leicestershire, Northampts and Rutland	22	3	1	6	1		11
Trent	39	2	1	7	3		26
Northumberland, Tyne and Wear	34	3	0	4	2		25
County Durham and Tees Valley	29	5	3	6	0		15
Norfolk, Suffolk and Cambridgeshire	44	0	0	0	0		44
Bedfordshire and Hertfordshire	16	0	0	0	0		16
Essex	20	0	0	0	0		20
Total	588	31	23	87	46		401

¹ Third party developments are those where a private contractor develops primary care premises on behalf of GPs or PCTs.

² Other & not known includes: (i) grants to owner-occupier GPs who have borrowed to purchase, build or refurbish premises; and (ii) improvement grants including for extensions and alterations to comply with the Disability Discrimination Act.

The NAO asked each of the PCTs within the six LIFT case study areas to supply details of comparable publicly funded primary care facilities. None of the PCTs could identify any such developments.

The Sandwell LIFT scheme, however, was able to provide comparable data between a third party scheme that was developed concurrently with a LIFT scheme. The third party development known as the Lyng Centre for Health and Social Care (the Lyng Health Centre) opened in June 2005. It replaced the Cronehills Health Centre and is a one stop primary care centre. The most comparable LIFT development is the Oldbury Health Centre which is the largest of the three first tranche LIFT developments in Sandwell.

A cost comparison of Oldbury Health Centre and the Lyng Health Centre is shown in Table 2.

Table 2

COST COMPARISON—A LIFT DEVELOPMENT AND A NEARBY THIRD PARTY DEVELOPMENT

	<i>Oldbury Health Centre (LIFT)</i>	<i>Lyng Health Centre (Third Party Development)</i>
Capital construction cost (£ million)	4.1	12
Square metres	2,260	5,760
Rental charge £/m ²	229	195
— construction and finance	151	178
— facilities maintenance ¹	16	17
— lifecycle	21	n/a
— partnering/LIFTCo management ²	33	n/a
— recovery of bid costs ³	8	n/a

¹ Maintenance in LIFT is inclusive of all maintenance across life of building, whereas under a conventional lease only scheduled maintenance is included.

² Partnering and LIFTCo management costs relate to business set up costs.

³ LIFT bid costs reflect that an exclusive contract for 25 years has been awarded to the LIFTCo. The rules on the number of schemes over which bid costs could be spread mean there will be no bid costs from scheme 7 onwards. This cost could otherwise be spread over developments for 25 years.

It is not possible to generalise from one example but the comparison demonstrates some interesting points. In this case construction and finance costs were 15% less per square metre in the LIFT development than in the third party development. The rental charge, adjusting for lifecycle maintenance costs which are not included in the Lyng development, was around 7% higher than in the third party development. Some differences between the LIFT Lease Plus Agreement (LPA) and a conventional lease could not, however, be taken into account in the above analysis. Unlike a conventional lease, LIFT rentals include all maintenance and repairs and can only be increased annually by the Retail Price Index (RPI). The capital costs associated with maintaining LIFT premises are, therefore, spread evenly over the 25 year contract period.

Comparisons between rental costs under conventional leases and the Lease Plus Agreement in LIFT are also problematic because of the different risk profiles. For example, in LIFT the tenants enjoy a greater degree of sanction against the LIFTCo than they would against a third party developer. In the event that the LIFTCo fails to carry out maintenance, the tenants can carry out the necessary work themselves and deduct the costs from the rent. Similarly, if an area of the building is unavailable for use the tenants are able to make deductions from the rent for that period. Moreover under a conventional lease, the tenant takes on the risk that defects appear in the building and that maintenance is more expensive than predicted.

Question 93–97 (Mr Richard Bacon): Population information

Mr Bacon referred to the PCT population data provided in Appendix 2 (p 38) of the Report by the Comptroller and Auditor General. This data refers to the total number of patients registered with the PCTs in the LIFT case study areas, as set out in their initial Strategic Service Development Plans. Mr Bacon asked whether the NAO could also supply for each case study scheme details of the number of patients registered with LIFT General Practitioners (GPs).

Data from the LIFT case studies (broken down by individual PCTs within the scheme where applicable) as at January 2005 is presented in Table 3.

Table 3

REGISTERED PATIENTS PER LIFT SCHEME

<i>LIFT Area</i>	<i>PCT patients</i>	<i>Patients registered with GPs in Tranche 1 LIFT premises</i>	<i>% of patients served by GPs in Tranche 1 LIFT premises</i>
East London LIFT	752,924	27,927	3.7
Newham PCT	314,956	27,927	8.9
Tower Hamlets PCT	230,000	0	0 ¹
City & Hackney PCT	210,000	0	0 ¹
East Lancashire LIFT	504,602	74,560	14.8

<i>LIFT Area</i>	<i>PCT patients</i>	<i>Patients registered with GPs in Tranche 1 LIFT premises</i>	<i>% of patients served by GPs in Tranche 1 LIFT premises</i>
Burnley, Pendle & Rossendale PCT	252,132	13,560	5.4
Hyndburn & Ribble Valley PCT	115,000	33,000	28.7
Blackburn with Darwen PCT	137,470	28,000	20.4
Ashton, Leigh & Wigan LIFT	301,419	32,320	10.7
Barnsley LIFT	237,973	38,561	16.2
Sandwell LIFT	320,348	20,299	6.3
West Bromwich & Wednesbury PCT	121,445	3,501	2.8 ²
Oldbury & Smethwick PCT	110,801	13,080	11.8
Rowley Regis & Tipton PCT	88,102	3,648	4.1
Barking & Havering LIFT	418,518	35,355	8.4
Barking & Dagenham PCT	171,000	17,200	10.1
Havering PCT	247,518	18,155	7.3

¹ While both Tower Hamlets and City and Hackney PCTs were partners in the East London LIFT scheme, the initial development was one building in Newham.

² The Birmingham Road scheme and the Whiteheath schemes in Sandwell relocated a single handed practitioner and a small practice both of which had smaller patient list sizes than other case studies. The focus of these schemes was less on GP provision and more on provision of wider primary care services.

Question 97 (Mr Richard Bacon): Cost of LIFT accommodation relative to total PCT funds for primary care accommodation

Dr Kohli, a GP working in the Manor Park LIFT building in Newham, East London, was invited by the Committee to appear as a witness following concerns he expressed to members of the Committee during a visit to the health centre about the affordability of LIFT developments. Dr Kohli submitted to the Committee a written statement and an analysis of the estimated 2005–06 cost of rents in LIFT premises per registered LIFT patient and rental costs in other primary care buildings per registered patient, based on information provided by Newham PCT (Ev 17–18).

Mr Bacon asked the NAO to prepare an analysis on a similar basis for all the case studies covered in the Report. Table 4 sets out comparable information for 2004–05 as it was difficult to obtain estimated 2005–06 information for the other PCTs.

Table 4

AVERAGE ANNUAL PRIMARY CARE RENT PAID PER PATIENT VERSUS AVERAGE RENT PER LIFT GP PATIENT

<i>(A)</i>	<i>(B)</i>	<i>(C)¹</i>	<i>(D)²</i>	<i>(E)¹</i>
<i>LIFT area</i>	<i>Actual PCT funding for primary care accommodation 2004–05 (£)</i>	<i>Average annual cost per patient (£)</i>	<i>PCT funding for GP premises in LIFT buildings in 2004–05 on a annualised basis (£)</i>	<i>Average annual cost per LIFT GP patient (£)</i>
East London	10,708,000	14.22	422,760	28.73
East Lancashire	2,815,000	5.58	2,451,480	32.88
Ashton, Leigh & Wigan	2,081,000	6.90	967,238	29.23
Barnsley	934,000	3.92	635,376	16.48
Sandwell	1,229,000	3.84	635,400	31.41
Barking & Havering ³	3,432,000	8.20	0	0
<i>2005–06 figures for Newham provided to PAC by Dr Kohli⁴</i>				
Newham PCT	3,223,099	10.20	899,180	32.20

¹ Patient numbers are derived from Table 1 of the C&AG's memorandum, Ev 19.

² Column D details the annualised PCT funding of GP accommodation for tranche one LIFT buildings for 2004–05. The LIFT funding has been annualised as, in some instances, the buildings only opened during 2004–05. LIFT funding is comprised of the annual rental charge payable by the PCT for premises and forms part of each PCT's overall primary care accommodation funding as detailed in Column B.

³ In 2004–05 the Barking & Havering LIFT building was fully occupied by PCT staff providing clinic services.

⁴ Dr Kohli provided the Committee with 2005–06 figures for Newham after discussion with the PCT (paragraph 3.1 above). The PCT revised those figures in the light of more up to date information.

It is difficult to draw conclusions from the above analysis as LIFT premises are new, purpose built and in excellent condition and generally provide more useable space than the existing stock of PCT premises, which are typically much older and in poorer condition.

Memorandum submitted by LIFT LOBI

INTRODUCTION: LIFT LOBI

LIFT LOBI is the Liaison Organisation for Business Investors in LIFT schemes; the representative body for private sector partners. The membership comprises 13 organisations; over 90% of the private equity investors in LIFT ventures around the country.

LIFT LOBI acts as a forum for debate and decision-making for members on all issues relating to LIFT and represents the interests and consensus opinion of its members.

We are grateful for this opportunity to provide Committee Members with our considered response to the NAO Report and hope that Members will find the information contained here useful.

NAO REPORT "INNOVATION IN THE NHS: LOCAL IMPROVEMENT FINANCE TRUSTS"

The National Audit Office Report on LIFT examines whether the scheme is able to support improved health care services while providing value for money. It finds that LIFT is an "attractive way of securing improvements in primary and social care"¹ and an "effective and flexible procurement mechanism"².

LOBI members welcome the positive findings of the NAO Report and the constructive recommendations contained therein. We believe that the benefits of the LIFT system are wide-ranging and it is gratifying to see these benefits identified by the NAO³:

- Provision of new purpose-built GP premises suitable for modern primary care.
- Integrated care: co-location of healthcare professionals helps to forge links between primary and social care with benefits for staff and patients.
- Flexible leases and share options help to resolve GP recruitment and retention problems.
- Local strategic direction and partnerships with community stakeholders ensures development is tailored to local circumstances.
- Advanced primary care centres and chronic disease clinics reduce pressure on secondary care.
- Rapid delivery of necessary primary care development where it is needed most.

VALUE FOR MONEY

Significant developments have taken place within the LIFT market since the publication of the NAO Report in May 2005. LIFT stakeholders have since identified the need for the development of a credible Value for Money (VFM) evaluation system which could be applied to all LIFT ventures.

LIFTCo's are contractually obliged to provide evidence of the value for money of potential schemes in comparison to both LIFT and non-LIFT developments. We recognise the Office for Government Commerce definition of Value for Money, and its assertion that simple benchmarking should not be seen as a substitute for a comprehensive VFM test.

We support the opinion of the NAO: "whole life costs over the length of the partnership are inevitably uncertain. The cheapest option may not, therefore, be the option which offers best value for money".

A Value for Money system will ensure that potential individual LIFT ventures are accurately judged using long-term criteria and local communities receive full value for money.

¹ C&AG's Report, p 2.

² *ibid*, p 3.

³ *ibid*, para 1.1 p 9, para 1.10 p 11.

LOBI has engaged collectively over the past three months in conceiving, developing and building such a comprehensive value for money system with Ernst and Young and with the support of the NAO and Partnerships for Health. The system will be used for the assessment of every past and future LIFT scheme. It carries the support and endorsement of all LOBI members. We continue to work to finalise and publicise this important system and hope that it can be used as a future model for procurement in other sectors.

THE FUTURE OF PRIMARY CARE AND LIFT

Our experience supports the view of the NAO in that PCTs do indeed welcome “a long-term approach under local strategic direction together with national support and standardised documentation”⁴. It is for this reason that we have closely monitored recent communications from the Department of Health regarding changes to the future role and configuration of PCTs, and how these changes may impact upon LIFT ventures.

LOBI notes the rapidity of recent Department of Health moves to alter the role of PCTs, from providers to commissioners of primary care. While we understand the desire to move forward with the modernisation of the health service, we encourage the Department to continue to consult widely on changes to the nature of primary and social care. Given the extremely positive Report from the NAO any reconfigurations to primary health care should continue to include LIFT as an essential element of the system.

The LIFT scheme has been tried and tested. It has been proven to work flexibly and effectively within a wide range of health frameworks to deliver on tangible health improvement goals. It strikes a vital balance between public and private sector involvement in an approach which offers breadth and focus. Reliable long term investment in healthcare facilities is ensured and can be channelled to areas of high deprivation which might otherwise be neglected under different procurement methods.

Dozens of communities have already been given a vital boost by LIFT ventures. It is crucial that they continue to be supported in this manner and that the scheme is expanded in order that more areas may benefit.

The Government White Paper on out-of-hospital care, due to be published at the end of 2005, will form the basis of future developments in health and community care. LIFT LOBI is engaging fully with the current pre-publication consultation process.

LIFT LOBI members look forward to the publication of the White Paper and to working with all partners to guarantee the future of modern, patient-led health care in England with LIFT at the heart of this vision.

Memorandum submitted by The Centre for International Public Health Policy

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

1. The methodology used by the National Audit Office is fundamentally flawed, being based on surveys of informants who have an interest in LIFT schemes.

2. Other than these biased interviews, there is no evaluation of value for money or the factors that underpin it. Specifically:

- There is no comparison of the LIFT proposals against other current or potential financing methods.
- There is no examination of risk transfer despite the unusually high levels of return to equity providers.
- The analysis of the financial models was contracted out to Operis, a PFI/PPP consultancy, and neither the models nor the evaluation are in the report.
- There is strong evidence that affordability (the capacity of the public sector to meet the cost of the unitary charge) may be a problem, but there is no analysis.

As such, the Report marks a new phase in the NAO’s problematic shift away from quantitative to qualitative analysis in its evaluation of PFI/PPP projects.

3. The NAO make clear that the new governance structures for the delivery of health and other public services could be problematic, but there is no attempt at evaluation.

⁴ C&AG’s Report, p 2.

Recommendations

We recommend:

(1) that the Committee of Public Accounts ensure that a proper, in-depth evaluation of NHS LIFT is undertaken, with due regard to quantitative data, and with respect to:

- value for money (as compared with other financing options, whether these are real or theoretical);
- the quantum of risk transferred to the private sector;
- the rate of return to private sector investors;
- affordability; and
- the effect of joint venture companies on public sector governance.

(2) that the Committee request from the NAO the financial models from the Department of Health that were given to Operis as part of its inquiry, and that these should be published. Included in the models we would expect to see:

- affordability calculations;
- income streams;
- anticipated sources of income (revenue-sharing arrangements);
- risk premium;
- rates of return;
- value for money calculations (Net Present Value and cash); and
- the apportionment of risk and liabilities in the event of project failure.

BACKGROUND TO LIFT

The Local Improvement Finance Trust (LIFT) initiative is being used to develop new primary and social care facilities for the NHS. LIFT involves the creation of a joint venture company within each LIFT locality in which representatives of central government and the local public sector own shares along with a private sector partner.

These vehicles raise private finance in order to develop a succession of projects over the 20-year life of the partnering agreement. They charge rents to primary care providers to service this debt—and provide profits for investors and contractors. This is repaid through NHS subsidy to GPs, primary care trusts and/or other health providers. Investment through LIFT, therefore, is ultimately paid for by the NHS.

A total of 42 schemes across England were approved by the DoH in August 2002, followed by a further nine schemes in November 2004. Building work has so far schemes valued at £866 million. This number will grow as more LIFT contracts are signed.

THE NAO REPORT'S TERMS OF REFERENCE

The NAO sought to assess whether LIFT has proved to be successful so far through attempting to answer four “high-level” questions. These were:

1. Will LIFT contribute to the better long-term delivery of local health services?
2. Does the LIFT structure include appropriate governance arrangements, incentives and accountability?
3. Have LIFTCos sufficient public and private skills and capacity to deliver and operate their programmes?
4. Will LIFT deliver the expected benefits in a way conducive to value for money?

These questions were together used to answer a general question: is LIFT a suitable vehicle to support improved primary and community care services that meet local needs while improving value for money? (page 36). However, the report is not structured around the four questions, but around the NAO’s “Dinner Party” approach (page 36), the aim of which is “to produce crisp, interesting report conclusions that can each be stated in 10–15 seconds.”

The conclusions that the NAO reached through this process were (page 36):

- The National LIFT programme appears an attractive way of securing improvements in Primary and Community Care.
- The local LIFT models appear to be an effective mechanism clearly demonstrating value for money; however, local management frameworks could be strengthened.

THE NAO REPORT'S METHODOLOGY

The NAO studied the national picture through two large surveys. One was sent to the private sector bidders who had competed for LIFT schemes; the other was sent to Project Directors from the public sector side. The NAO consulted frequently with the Department of Health and Partnerships for Health, and used these two bodies to provide details of potential interviewees.

The NAO also carried out case studies of the six LIFT schemes that had been signed at this stage of their fieldwork. They also carried out in-depth interviews with “key stakeholders”, including Project Directors, private sector bidders, clinicians, Primary Care Trusts, Strategic Health Authorities and local authorities.

A survey was sent to Local Pharmaceutical Committees in each of the six case study areas following a request by the National Pharmaceutical Association, which had expressed concerns that pharmacists felt they had not been fully included in the LIFT process.

Evaluation of the financial models of the six case studies was provided by Operis, a management consultancy.

OUR CRITIQUE OF THE METHODOLOGY

(i) *Project sampling*

The NAO sample was restricted to the first projects to close. As such, the NAO's sample may not represent the full picture of the procurement. Looking only at the projects that were most successful in terms of the procurement process makes it hard to assess how well LIFT projects are progressing generally. The report might have been more representative had it included analysis of LIFTs where organised opposition had started to develop.

The NAO did receive letters from people complaining about their local LIFT schemes but the report did not include these cases in its evaluation.

(ii) *Selection of informants*

The NAO's choice of informants could lead to biased results. In the two national surveys, it only contacted private sector bidders and LIFT project directors. The experiences and views of staff and service users were not incorporated. Both private sector bidders and project directors have an obvious interest in providing the NHS with a positive account of their projects. This is also, of course, the case with PFI and indeed public procurement processes. However, unlike PFI and public procurement, LIFT involves the promise of future projects, and it may therefore be particularly difficult for those involved to provide objective evidence.

(iii) *The contracting out of the financial analysis*

The Committee may question the legitimacy of outsourcing the review of the financial models to Operis, a consultancy company which advises private sector bidders and banks involved in PPPs.

(iv) *Evaluation of performance*

The NAO notes that all of the LIFT schemes it studied have failed to conduct proper post-project evaluations. Of the six LIFT projects examined by the NAO, just one had developed a post-project evaluation plan. However, the NAO fails to point out that these LIFT schemes—and the DoH itself—are consequently in breach of published guidance. The NAO seems not to be aware of this guidance. Of evaluation, it says there is “no clear guidance recommending either its nature or timing” (page 30, para 3.8).

But this is wrong. In January 2002, the DoH published guidance to assist NHS bodies involved in capital schemes in the process of evaluating their completed projects. This guidance, *The Good Practice Guide: Learning Lessons from Post-Project Evaluation*, states that such evaluations are “an essential aid to improving project performance, achieving best value for money from public resources, improving decision-making and learning lessons” (page 1).

This guidance sets out a four-stage process of evaluation and a number of technical considerations. In addition, it advises NHS bodies to carry out an initial post-project evaluation of project outcomes six months after the facility has been commissioned.

It would appear that the LIFT schemes studied in this report are in breach of this guidance, since in most cases some buildings have been operational for more than six months. In addition, since all LIFTs involve Partnership for Health—a representative of the DoH—arguably the DoH is itself in breach of its own published guidance.

While the details of this guidance have the status of “advice” to NHS bodies, the requirement to evaluate and learn from projects is in fact mandatory for all DoH projects with a cost in excess of £1 million. Further, guidance specific to LIFT states that LIFTCos should “regularly monitor and report the standard of performance” of the services they provide (Standard Strategic Partnering Agreement, version 4, Section 2).

(v) *Value for money comparison*

The NAO does not produce direct quantitative comparisons with public sector finance or with GP-managed developments. The NAO takes the DoH line that value for money can be demonstrated through the running of a competitive procurement, in addition to some benchmarking and an assessment of rents by a district valuer.

We would question this proposition, which runs against the process operating under PFI, in which a public sector comparator is used to test the value of the PFI proposal against a theoretical publicly financed scheme.

It could be argued that the PSC system is not appropriate for LIFT schemes, since public finance is rarely available for large-scale capital investment in primary care. Instead, investment has primarily been through debt-financing in the form of interest-free loans from the General Practice Finance Corporation (GPFC). These loans are paid back by the NHS in the form of a number of different types of subsidies to GPs.

However, there is no reason why the government could not produce comparators, based either on public financing or financing through the GPFC in order to provide information about base costs. The production of a fully costed “theoretical” publicly financed project has taken place within the mainstream PFI programme since the initiative’s conception.

In addition, it seems the NAO is unaware of recent examples of public sector funded health centres, such as those built with London Implementation Zone grants. Anecdotal evidence suggests that these projects have been very successful. For example, Greenwich’s Fairfield Grove Health Centre was highly commended by the Commission for Architecture and the Built Environment (CABE 2002).

(vi) *Risk transfer and the rate of return*

The NAO presents little data with which we might make inferences about the value for money of LIFT projects. This is despite the fact that local NHS bodies were sceptical. For example, some of the Strategic Health Authority representatives in the NAO’s case study areas expressed concerns that initial business cases did not sufficiently explore the risks of LIFT, and that it was hard to have complete assurance about value for money for an untried initiative.

Meanwhile, the quantum of risk transfer is not explored by the NAO, despite the higher rates of return in LIFT (case study range is from 14.3% to 15.9%) compared to the average in PFI schemes (12.5% to 15% in the NAO’s comparator PFI schemes). Despite this, the NAO agrees with the government that LIFT is “clearly value for money”.

(vii) *Affordability*

Affordability refers to the income required from the public sector to pay the unitary charge to the LIFTCO. The NAO Report does not produce any affordability calculations, despite the fact that GPs have expressed concerns that smaller GP premises may lose funding because the higher lease costs of LIFT schemes within the locality are tying up resources (Pulse magazine, 30 April 2005).

In addition, representatives from the National Pharmaceutical Association, the British Dental Association and local authorities told the NAO that they had concerns about rental costs. Indeed, the NAO comments that “there is a common perception from these groups of prospective tenants that the higher cost of LIFT, compared to current rent payments, outweighs the benefits of new, purpose built premises” (page 21, para 2.14). The Report makes no final conclusion on affordability.

(viii) *Conflicts of interest*

The NAO makes some criticisms in this area and recommends stronger management arrangements. Its report expresses concern about the potential conflicts of interest, in particular the issue of PCT directors sitting on the LIFTCO Board. It comments (page 32): “if the LIFTCO was in financial difficulties, as a LIFTCO director a Primary Care Trust employee might have conflicting pressures between helping the LIFTCO and protecting the interests of the Primary Care Trust” (para 3.13).

The NAO points out (page 32, para 3.13): “the public sector director, in the role as a LIFTCO Board Member, has a fiduciary duty to act in the interests of the LIFTCO and not for the Primary Care Trust.” The NAO provides no evaluation of how these difficulties have impacted on issues such as accountability, transparency and the avoidance of conflict in the governance procedures of the six LIFT areas studies.

OUR CONCLUSIONS AND RECOMMENDATIONS

Conclusions

1. The methodology used by the National Audit Office is fundamentally flawed, being based on surveys of informants who have an interest in LIFT schemes.

2. Other than these biased interviews, there is no evaluation of value for money or the factors that underpin it. Specifically:

- There is no comparison of the LIFT proposals against other current or potential financing methods.
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- There is strong evidence that affordability (the capacity of the public sector to meet the cost of the unitary charge) may be a problem, but there is no analysis.

As such, the Report marks a new phase in the NAO's problematic shift away from quantitative to qualitative analysis in its evaluation of PFI/PPP projects.

Recommendations

We recommend:

(1) that the Committee of Public Accounts ensure that a proper, in-depth evaluation of NHS LIFT is undertaken, with due regard to quantitative data, and with respect to:

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- the rate of return to private sector investors;
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- the effect of joint venture companies on public sector governance.

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- anticipated sources of income (revenue-sharing arrangements);
- risk premium;
- rates of return;
- value for money calculations (Net Present Value and cash); and
- the apportionment of risk and liabilities in the event of project failure.

SUPPLEMENTARY NOTE ON LIFT'S MOVE INTO CLINICAL SERVICES

The NAO comments that in the fourth wave of LIFT, LIFTCos will be encouraged to “expand the range of services provided” (page 32, para 3.16). What the NAO is referring to here is the delivery, through the private sector, of clinical primary care services.

In a document from Partnerships for Health that was circulated to private sector bidders, healthcare companies and their advisers described how clinical services will be delivered through LIFT under the alternative provider medical services route.

The clinical services which may be included in LIFT's fourth wave are as follows:

1. *Essential Medical Services*: including care for those who are ill, or believe themselves to be ill, but recovery is expected.

2. *Replacement Additional Services*: These services include Cervical Screening, Contraceptive Services, Vaccinations and Immunisations—excluding childhood immunisations and certain travel vaccinations, Childhood Vaccinations and Immunisations, Child Health Surveillance Services, Maternity Medical Services and Minor Surgery.

3. *Enhanced Services*: These include Intrapartum Care, IUCD Fitting, More Specialised Services for patients with Multiple Sclerosis, More Specialised Sexual Health Services, Alcohol and Drug Misuse Services, Provision of Near-patient Testing—shared care drug monitoring service, Provision of Intermediate Care and First Response Care, Specialised Care of Patients with Depression, Care of the Homeless and Anticoagulation Services.

4. *Out-of-Hours Services*

5. *A combination of any of the above*

This proposal will dramatically reduce the public sector role in primary care services.

18 October 2005

National Audit Office's response to the memorandum submitted by the Centre for International Public Health Policy

CONCLUSIONS AND RECOMMENDATIONS

1. The briefing note dated 18 October 2005 from the Centre for International Public Health Policy (CIPHP) on the National Audit Office Report "Innovation in the NHS: Local Improvement Finance Trusts" criticises the methodology used by the National Audit Office. The note suggests that the methodology used is based on surveys of stakeholders with a vested interest in LIFT and that, other than these interviews, there is no evaluation of value for money or the factors that underpin it. The note says the National Audit Office Report marks a new phase in a shift away from quantitative towards qualitative analysis. The note also says that potential delivery problems arising from new governance structures are identified in the Report but not evaluated.

2. The National Audit Office has considered these points carefully and responds to the methodological issues made below. This note provides clarification on appropriate elements of the National Audit Office's fieldwork. It also refers to the results of further analysis carried out as a result of the hearing of the Committee of Public Accounts on 17 October 2005.

USE OF QUALITATIVE METHODOLOGY

3. The National Audit Office attaches importance to both quantitative and qualitative analysis. In reports on subjects such as LIFT, where an initiative is at an early stage, there is room for judgement on how it will develop and whether its ambitions will be fulfilled. The report carried out both qualitative and quantitative analysis as set out in paragraphs 14–17 below.

EVALUATION OF VALUE FOR MONEY

4. The following methodological points were made:

- (i) There is no comparison of LIFT proposals against other current or potential financing methods.
- (ii) There is no examination of risk transfer.
- (iii) There is some evidence that affordability may be a problem but no analysis.

Comparisons against other methods

5. The National Audit Office Report compared LIFT to both traditional public capital investment and third party development (paragraphs 1.6–1.9). The reasons why the final Report did not quantify the cost of the alternatives and compare them to the cost of LIFT are expanded on below.

6. There was a lack of information on suitable comparators procured using alternative mechanisms. The National Audit Office considered comparing the cost of LIFT to third party developments and noted the different financing and contract structures in such developments, together with different whole life cost profiles. Moreover, analysis of individual leases including rent review clauses and the extent of further charges such as utility and insurance services would have been necessary. The National Audit Office met with several third party developers who were unwilling to share detailed data.

7. The National Audit Office asked each PCT and LIFTCo to provide examples of suitable primary care developments by way of comparison. It found that public finance in the form of central funding was rarely available and usually only for small scale refurbishment and redevelopment. At present improvement grants of up to £100,000 are available so long as there is a commitment that the development will remain in the NHS for 10 years.

8. The CIPHP briefing paper refers to funding under the London Improvement Zone (LIZ) which was available until 1999. It cites the example of the Fairfield Grove Health Centre, Greenwich which was completed in 1996 for a contract value of £1.5 million. Fairfield Health Centre offers integrated primary

health care facilities for general medical practice, community services and other primary care practitioners. Its size and the fact that it was completed nearly 10 years ago suggest that it is not a good comparator for LIFT.

9. In the light of the interest shown by the Committee of Public Accounts in such comparisons the National Audit Office approached the PCTs involved in the case studies in its report to try again to find meaningful comparators. Information on a comparable third party development—the Lyng Centre for Health and Social Care is provided in the supplementary memorandum to the Committee. The PCTs could not find any comparable centrally funded developments.

Risk transfer

10. The National Audit Office Report did not set out details of the risk transfer arrangements in LIFT as it identified no value for money concerns about the allocation of risk under the LIFT model.

Affordability

11. The National Audit Office Report discussed affordability—some tenants were concerned about the rental costs they faced (paragraph 2.14). Representatives from the National Pharmaceutical Association, the British Dental Association and Local Authorities told the National Audit Office that they had concerns over rental costs. The National Audit Office asked for relevant background and received qualitative feedback rather than quantitative data.

12. Wide consultation at the time the NAO Report was carried out (paragraphs 16 and 17 below) did not reveal any general affordability issues for PCTs. The business cases reviewed for the case studies had considered affordability for the local health economy. After the Report was published, in the light of experience as developments came on stream, affordability questions were starting to be raised. During a visit by members of the Committee of Public Accounts to a LIFT development, arranged by the National Audit Office after the Report was completed, this issue was raised by Dr Kohli, a GP in the LIFT development. He also raised the issue in the 17 October 2005 Committee Session. As a result, the National Audit Office gathered relevant information, which it has included in its supplementary memorandum to the Committee.

NEW GOVERNANCE STRUCTURES

13. The National Audit Office Report found some potential governance problems which it exposed in the Report (paragraphs 3.11–3.15). It set out the potential implications of these but it found no tangible delivery issues at that stage—possibly because the LIFT schemes were at an early stage.

OTHER ISSUES

14. The National Audit Office's methodology was set out in detail in the Report to allow scrutiny. The CIPHP main criticisms are that the Report relies on surveys of interested parties, it looks at only the first six projects completed and that the Report is not structured around the four main high level questions it identified. The independent quality review of the Report commissioned by the National Audit Office concluded that a range of appropriate methodologies had been used and gave the Report a good mark—an average of 4.1 out of five. Further information on methodology is set out below.

15. Questionnaires were issued to three main interest groups, principally to gain an understanding of the adequacy of the standardised procurement process devised by Partnerships for Health. These were: all LIFT Project Directors; shortlisted bidders across the 42 LIFT schemes extant at that time; and the Local Pharmaceutical Committees in each case study areas.

16. The National Audit Office aimed to obtain a balanced view of the scheme by consulting widely across parties with differing views on LIFT, although not all agreed to speak to the National Audit Office team. As is normal in National Audit Office studies, the team had access to a panel of experts who were invited to comment on the audit plan and the structure and draft of the Report, thereby providing quality assurance. The panel for the LIFT Report included amongst others a dental practitioner, a general practitioner and the Chief Executive of a PCT.

17. A key element of the evidence was provided from analysis of six case studies (Appendix 1, paragraph 8). The first six schemes to have completed the procurement process were chosen for practical reasons and because they represented all three waves of LIFT. These case studies were used to identify best practice and lessons for future LIFT developments. A wide range of stakeholders were interviewed in the local health economy for each case study and key documents were reviewed. The National Audit Office was aware of concern in some areas about LIFT schemes. It flagged this up in the Report (paragraph 2.4) but the projects were not advanced enough to be analysed as case studies.

18. The CIPHP note suggests that the National Audit Office team was unaware of Department of Health guidance “Learning from Post Project Evaluation” although this guidance is referred to in paragraph 3.8 of the Report. This paragraph of the National Audit Office Report went on to say “there is no clear guidance

recommending either its nature or its timing” in relation to the post project evaluation of LIFT. This latter reference relates to the National Audit Office’s concern that the Department and Partnerships for Health should issue detailed guidance—as referred to in recommendation 9 of the Report.

Supplementary memorandum submitted by the Department of Health

Question 21 (Kitty Ussher) Dental facilities in LIFT developments

There are no formal guidelines on the number of dental facilities to provide within a LIFT development. Dental services can be incorporated into LIFT schemes if the local circumstances mean that it is appropriate and viable to do so, but it is not compulsory to incorporate dental facilities. Primary care trusts (PCTs) can offer other assistance to dental practices to improve access to NHS services, including help with the cost of premises, if they consider it appropriate to do so. PCTs will have greater opportunity to support the development of dental services when they take over responsibility for the local commissioning of all primary dental care services from April 2006.

Of the 33 LIFT buildings so far open to patients, 11 include a dental facility. For example, the recently opened Walker Centre in Newcastle provides a community dentist and three dental training chairs used by students from the local dentist hospital.

Supplementary question (Mr Richard Bacon)

LIFT Projects Guaranteed Minimum Annual Return

There is no guaranteed minimum annual return on a LIFT project. The financial model for each individual LIFT financial close will detail the expected rate of return for the investors in the LIFT Company. These rates of return are not guaranteed, but are dependent on the performance of the LIFT Company in managing its assets and supply chain.

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